



Mental Health
Commission
of Canada

Commission de
la santé mentale
du Canada

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

CROSS-SITE REPORT

Geoffrey Nelson, Jennifer Rae, Greg Townley, Paula Goering, Eric
Macnaughton, Myra Piat, Nathalie Egalité, Ana Stefancic, Sam Tsemberis

Mental Health Commission of Canada National Qualitative Research Team
for the At Home/Chez Soi Project
February 21, 2012

CROSS-SITE REPORT

TABLE OF CONTENTS	
Key Messages	4
Executive Summary	6
Acknowledgements	9
Introduction	10
Brief Methodology	
Fidelity Evaluation	12
Qualitative Evaluation of Implementation	13
Findings	
Housing First Program Theory	14
Housing First logic model	14
Critical ingredients as viewed by participants	14
Early outcomes as viewed by participants	15
Longer-term outcomes anticipated	16
What Worked Well in Implementation	16
Strengths: Fidelity evaluation	17
Factors that facilitated implementation: Qualitative evaluation	17
<i>Site factors</i>	17
<i>Organizational/team/service factors</i>	17
<i>Mental Health Commission of Canada</i>	18
<i>Partnership factors</i>	18
What Worked Less Well in Implementation	20
Challenges: Fidelity evaluation	20
Factors that hindered implementation: Qualitative evaluation	20
<i>Site factors</i>	20
<i>Organizational/team/service factors</i>	21
<i>Mental Health Commission of Canada</i>	22
<i>Partnership factors</i>	23

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.

TABLE OF CONTENTS

INNOVATION: Fidelity and Adaptation	24
Fidelity	24
Contextual influences and program adaptations	24
<i>Community influences</i>	24
<i>Nature of the population</i>	25
Local innovations to the programs	26
Cross-cutting Themes and Lessons Learned	
Developing a Broadened and Deepened Understanding of Service Philosophy: The Meaning of Choice Over Housing and Treatment Options	28
Delivering on the Promised Intensity and Breadth of the Support Model	28
Enhancing Staff Capacity	29
Focusing on Housing Procurement Strategies	30
Clarifying Accountability and Governance	30
References	31
Appendices	
1. Project Structure and Description of the Five At Home/Chez Soi Project Sites	33
2. Principles of Housing First	40

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 (program fidelity), including what worked well and what worked less well in implementation, and adaptations and innovations at the five sites.
- Participants generally agreed with the Housing First logic model, which includes (1) the separation of housing and support, (2) choice over both, (3) provision of a broad range of support and (4) meeting participants' basic needs for independent housing, income and health care, provided within a harm-reduction approach without any preconditions about participation in psychiatric treatment or sobriety. This approach was seen to facilitate early engagement, improvements in formal and informal supports, and in participants' mental health.
- 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 is strong with more than 70 per cent of program ingredients rated three or above on a four-point scale, which compares favourably with Housing First fidelity by other North American teams. Factors affecting implementation included site factors (e.g., richness of resources and potential partnerships), team/organizational/service factors (e.g., leadership, team cohesion, burnout/self-care issues), and resources provided by the Mental Health Commission of Canada (a coordinated training strategy and the presence of a Site Coordinator). Contextual factors that required innovation included systemic housing barriers, complex needs, and the nature of the local population, including the involvement of, and respect for, preferences of Aboriginal and racialized communities.
- Separation of housing and support was a particularly strong facet of implementation, though the fidelity team suggested that particular attention be paid to respecting this separation for participants who require rehousing.
- Programs are doing an excellent job at providing affordable, private housing integrated within regular neighbourhoods, though some participants were concerned about loneliness, and social integration was also identified by the fidelity reports as an area requiring improvement.
- Teams were relatively good at respecting participants' choices about the nature and location of housing, especially when using "bottom up" search strategies. However, the notion of choice over housing could be expanded to include supportive and shared housing options for participants who prefer these.
- Ensuring early access to housing is a challenge across all sites. Given barriers such as supply, stigma and discrimination, the importance of having a nimble housing agency whose primary interests lie with the participant and clinical team is apparent.
- Sites were relatively strong at providing care in accordance with the Housing First philosophy (i.e., strong at respecting residents' choices over participation in treatment), but less so at using active, motivational approaches. A challenge for all sites is in incorporating persons with lived experience into the ongoing operation of all facets of the project.
- Implementation of case management support features (e.g., small caseloads, frequency of meetings, intensity and location of support), was a strength, although one key aspect of the model (participation in hospitalization and discharge decisions) was noted as an area requiring attention.
- The greatest challenge for teams going forward is in meeting the broad array of support needs, including both treatment-related and recovery-oriented supports. This challenge was especially apparent amongst Intensive Case Management teams that must broker arrangements for these support needs.
- Both the risks of staff burnout (e.g., intensity and complexity of support) and its protective factors (e.g., leadership, cohesion, team self-care strategies) require attention.

- Recommendations for improvement include the integration of motivational approaches in daily practice, focusing on active engagement of persons with lived experience, the development of alternatives to scatter-site housing, the use of recovery-oriented approaches, the development of an array of services, sharing knowledge across teams, focusing on team development, better linking of housing and clinical teams, developing explicit approaches for rehousing, continuing to cultivate relationships with landlords and developing a program accountability structure.

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 presently being implemented in Moncton, Montréal, Toronto, Winnipeg and Vancouver. The present study examined the first phase of implementation, using a mixed methods strategy. In particular, the study sought to understand the extent to which the interventions met fidelity standards, to better understand the reasons behind implementation successes and challenges, and to appreciate how the interventions have been adapted to local contexts. The quantitative data were gathered by an external Quality Assurance team, which produced 10 fidelity reports for the five sites (excluding site-specific arms), and a summary report. In addition, a national key informant report and site qualitative implementation evaluation reports were produced. The present report synthesizes these and presents findings related to: (1) key intervention logic model ingredients; (2) what's working well and not well in implementation, (3) adaptations to local context, and (4) cross-cutting themes and lessons learned.

In accordance with the Pathways/Housing First logic model, respondents suggested that the key ingredients of the intervention consisted of immediate access to housing and comprehensive, high-quality support, guided by a philosophy that enables choice and eschews participation contingencies, such as the need to be medication compliant or substance-free. In accordance with this, program participants emphasized the importance of skilled, non-judgmental staff members who provide a level of support beyond regular 9 to 5 hours, and in home and community settings. Again in line with the envisioned logic model, the early outcomes experienced included engagement in treatment and housing, as well as increased formal and informal community support, although there were challenges in providing the broad array of supports promised by the model (particularly for Intensive Case Management teams - ICM); some housed participants were concerned about social isolation, and early access to housing was a difficulty across all sites. In view of systemic housing access barriers, a key, but largely tacit, aspect of the Housing First logic model appears to be the process by which the housing providers are chosen, and by which they work with landlords and property managers to procure housing stock that matches participants' preferences.

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 is strong with more than 70 per cent of program ingredients rated three or above on a four-point scale, where four indicates the highest level of fidelity. These findings compare favourably with Housing First fidelity by other North American teams. The domain of Separation of Housing and Support was the strongest area of implementation, indicating that the sites were doing an excellent job of providing housing without psychiatric or substance use treatment contingencies, and were able to deliver mobile support to participants irrespective of their place of residence. The domain Housing Choice and Structure was also generally strong, indicating that sites were doing an excellent job of providing integrated, private and affordable housing. Programs were also relatively strong at finding housing that fit with participants' choices over its nature and location, though they were generally challenged by availability, in particular, their ability to help participants move in quickly, which was a relative weakness in all the sites. The domain of Service Philosophy was also relatively strong, but mixed. While programs scored quite high in respect to residents' choices about participation in treatment, they scored less well in their ability to engage reluctant participants through the use of person-centred planning and motivational approaches. The domain of Service Array (i.e., the ability to provide a broad range of treatment and recovery-oriented supports) received the lowest scores overall, with ICM teams having particular challenges in this regard.

The qualitative results suggest a number of factors impacted on implementation and are related to the particular site, organizational factors related to the teams, partnerships within the community and support provided by the Mental Health Commission of Canada (MHCC). In terms of site factors, the size of the community appeared significant. For instance, having a relatively small, cohesive community (e.g., Moncton) facilitated information sharing and partnership development (e.g., with landlords), but could negatively impact the privacy of participants. The richness of the service

environment also impacted on implementation, making it easier for the project to draw on existing resources to provide a broad array of support, but also potentially causing a challenge, as some participants in one site had existing resources withdrawn upon entering the study. In general, sites were able to draw on a number of partnerships as they implemented the program, which was seen as a “bridge” for bringing a number of resources to bear for the benefit of participants. Sites were able to build some relationships with formal mental health services, as well as with agencies external to the formal system, such as landlords, income assistance and the police. The reports also indicated that additional partnerships required establishing or strengthening, such as with hospitals, substance use specialists and the court systems. Partnerships with organizations of people with lived experience were also important in facilitating the involvement of persons with lived experience within the project.

In terms of team/organizational/service factors, leadership was identified as critical, as provided, for instance, by clinical leaders and Site Coordinators. Multidisciplinary team make-up is also regarded as critical in adequately responding to the wide-ranging, complex needs of participants. Despite initially strong motivation, burnout and self-care were identified as emerging issues for team members, given the often complex, intense nature of the work. Stakeholders also noted the importance of professional self-care and the overall development of positive team relationships. Key informants affirmed the importance of having a clear organizational structure so that staff can better understand their roles in relation to one another and problem-solve issues quickly. A final factor impacting implementation concerned the resources provided by the MHCC, including a centrally coordinated training strategy, which was generally valued, and the provision of local Site Coordinators, who provided leadership at the site level and were able to mediate between the needs of local sites and the concerns of the overall project leaders.

The implementation evaluation also examined how sites adapted and innovated within their local environments. Access to housing was a challenge that all sites faced. In addition to issues of supply, including limited access to supportive housing options for participants who preferred these, sites also faced issues relating to stigma and discrimination. These challenges were exacerbated in some cases by the housing procurement strategy initially adopted by the site and by continuity of care issues between the research, clinical and housing teams. Sites have begun to address these challenges by adopting a “bottom up” approach to housing procurement, by making conscious approaches to involve landlords in appreciation events and as part of the support team. The key informant interviews suggested that sites need to more explicitly consider governance issues relating to the coordinated functioning of the housing and clinical teams. The complexity of care required by participants was another ongoing contextual challenge, which sites have begun to address by implementing trauma-informed care, by forming a solvent abuse network and providing a modified approach to housing to address the needs of participants with solvent abuse issues in Winnipeg, and by forming a Clinical Support Team to address complex clinical care issues in Toronto. From the outset, these two sites have also made conscious efforts, through their “third arm” interventions, to adapt the Housing First model to address the unique perspectives and support preferences of Aboriginal participants in Winnipeg through an Aboriginal Cultural Lens committee, and to provide culturally competent care for racialized groups in Toronto, delivered within an anti-racist/anti-oppressive framework.

A first cross-cutting theme concerns the philosophical grounding of the Housing First model, and relates to the project’s evolving practices related to the concept of choice. While teams were committed to respecting residents’ choices regarding participation in treatment, the fidelity reports emphasize that respect for choice should not be confused with a laissez-faire approach, and that the teams require greater attention to integrating motivational strategies into their daily practices to engage reluctant participants. The implementation evaluation results also point to the project’s overall challenge in implementing mechanisms for incorporating the perspectives and preferences of persons with lived experience into overall program operations. Finally, the results point towards a reconceptualization of how choice over housing is considered, and the possibility of broadening the range of options for participants to include supportive and shared housing arrangements for those who would prefer these, because of concerns about isolation, high support needs, or for cultural reasons.

A second theme concerns the challenges faced by the teams in delivering on the promised scope of the Housing First model, in the face of the complex needs of participants. Though the teams have achieved success in delivering on items such as intensity of visits and after-hours support, providing such intense, frequent support over a wide geographical area for clients with complex support needs could result in care provision that is oriented more towards “fighting fires” than recovery. Moving forward, teams are moving towards recovery-oriented care, and turning their attention more towards supported employment.

Challenges with staff burnout and retention associated with providing such intense, complex support was a closely related issue, and a third cross-cutting theme. To address this, greater attention going forward should be paid to team self-care and to related issues such as team leadership and cohesion.

Another theme concerned the importance of the housing procurement strategy in light of systemic access barriers that are causing delays in housing some participants. To address this challenge, the qualitative results highlight the importance of having a nimble agency whose actions are directed primarily by the clinical team and the needs of participants, and whose interests are not unduly compromised by the need to maintain landlord relationships for other client groups.

The final theme focused on clarifying accountability and governance. The need for a clearer accountability structure was noted.

ACKNOWLEDGEMENTS

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

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

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.

Projet Chez Soi Montréal – Projet de recherche et de démonstration sur la santé mentale et l'itinérance: Rapport d'implantation – Phase de déploiement (1er année: 10-2009 à 12-2010) (juillet, 2011) by Marie-Josée Fleury, Catherine Vallée, Roch Hurtubise, Alice Landry, and Guy Grenier.

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.

The five site reports can be accessed on the website of the Mental Health Commission of Canada:
<http://www.mentalhealthcommission.ca/English/Pages/homelessness.aspx>

Additionally, this report is based on 10 fidelity assessment reports conducted by an external Quality Assurance (QA) team and the following report conducted by the National Qualitative Research Team.

Macnaughton, E., & Eckerle Curwood, S. (2011, September). *Implementation of the Mental Health Commission of Canada's At Home/Chez Soi project: Report on interviews with national and fidelity team key informants.*

Thanks also to each of the sites and to Cameron Keller for reviewing and providing feedback on an earlier draft of this report, to Susan Eckerle Curwood for her assistance on the qualitative research, and to Julianna Walker, Sue Goodfellow, and Dean Waterfield for their assistance with the fidelity assessments.

INTRODUCTION

This report presents the overall findings emanating from the implementation of the At Home/Chez Soi project.¹ This pan-Canadian project is funded by the Mental Health Commission of Canada (MHCC)². It is 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 builds on existing evidence and knowledge and applies 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 has been 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 initial implementation of the project during the period when participants were recruited into the study (October 2009 to June 2011). The At Home/Chez Soi project is a randomized controlled trial (RCT) of Housing First versus Treatment as Usual (TAU) (Goering et al., 2011; Nelson, Goering, & Tsemberis, in press; Tsemberis, Gulcur, & Nakae, 2004). Nested within each of these two experimental conditions are two groups of participants: those with high needs, who receive support from Assertive Community Treatment (ACT) teams in the Housing First condition, and those with moderate needs, who receive 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 have developed a third arm. More information on the principles of Housing First can be found in Appendix 2.

There are two main objectives of this research:

- 1. To determine the program components and their fidelity, including:**
 - a. the most important program components of Housing First/ACT, Housing First/ICM, and, optionally, Housing First/site-specific “arms” or interventions (logic model verification), and
 - b. the fidelity with which they are implemented (fidelity evaluation);
- 2. To identify issues in the process of implementation, including:**
 - a. the strengths and weaknesses of implementation of the program components for the purpose of program improvement (formative evaluation), and
 - b. the ongoing processes of adaptation and innovation of the programs to changes in the larger community environment (developmental evaluation).

Corresponding to the two objectives of the mixed methods research noted above, there are two sets of research questions:

- 1. LOGIC MODEL VERIFICATION AND FIDELITY EVALUATION QUESTIONS**
 - a. What are the most important program components of Housing First/ACT, Housing First/ICM, and, optionally, Housing First/site-specific “arms” or interventions at each site?

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 MHCC is a national not-for-profit organization that was established to focus national attention on mental health. While it is funded by the federal government, it operates at arm's length from it. The work of the MHCC is currently focused on a number of key initiatives including At Home/Chez Soi, as well as the development of a mental health strategy for Canada, efforts to end stigma and discrimination faced by Canadians with mental health issues, and the development of a knowledge exchange centre.

- b. What is the theory of change (Mowbray, Holter, Teague, & Bybee, 2003) that links the program components to the outcomes (e.g., improved housing stability)?
- c. What are the reasons for any inconsistencies between planned and actual implementation?
- d. To what extent is there congruence or incongruence between the main program components of the Housing First/ACT, Housing First/ICM, and, optionally, Housing First/site-specific “arms” or interventions and the implementation of program components, as determined by the fidelity assessment tools implemented by a Quality Assurance (QA) team?

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

- a. What is working well and what is not working well in terms of program implementation?
- b. What challenges and barriers have emerged as the programs have been implemented?
- c. What factors have helped the implementation of the programs to go smoothly?
- d. How have the research, housing services, ACT staff, ICM staff, site-specific “arms” or interventions, and other stakeholders (e.g., consumers, program staff, housing providers) been working together?
- e. What feedback do consumers have about what is helpful and what is not helpful about Housing First/ACT, Housing First/ICM, and Housing First/site-specific “arms” or interventions?
- f. What are the key factors in the program’s environment (e.g., the larger community, the network of services) that are influencing program implementation?
- g. How have the programs had to adapt to changes in the environment?
- h. What new program innovations have resulted from changes in the environment?

BRIEF METHODOLOGY³

MIXED METHODS APPROACH

A mixed methods approach (Morris & Niehaus, 2009) 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, formative evaluation (Patton, 2008), and the influence of contextual factors on implementation and how programs change and adapt to such influences, developmental evaluation (Patton, 2011).

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, providers and a person with lived experience representative. 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). 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. 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), 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—a member of the QA team and a local consumer representative — and lasted approximately one and a half hours with 8-12 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 the most recent treatment plan and assessments. The total sample included 84 staff interviews, 10 consumer focus groups and 100 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 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

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

each visit, the QA team prepared a two-or three-page 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. The 10 reports were first sent out as drafts to 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. The ratings and the accompanying explanatory content are used as sources in this report.

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, 64 key informant interviews and 35 focus groups with 211 participants were conducted by site researchers between May 2010 and March 2011. 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 (Macnaughton & Curwood, 2011). The total sample included 283 participants.

Data collection. Common key informant and focus group protocols were used across the sites that focused on: (1) program logic model and fidelity issues, and (2) formative developmental 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 national-level interviews focused on activities to strengthen fidelity, as well as the process of conducting the fidelity evaluation visits (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.

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. This cross-site report relied on the national-level interviews and the site reports for its data, rather than reviewing transcripts or other data from each site. For the cross-site analysis, members of the National Qualitative Research Team and the QA team read the five qualitative implementation site reports and the five ACT and five ICM fidelity reports. A teleconference was held in which the members of these two teams shared their impressions of the reports. From this discussion emerged a framework for analyzing three topics related to implementation and fidelity: (1) Housing First program theory, (2) what worked well and worked less well in implementation, and (3) contextual influences and resulting adaptations and innovations. Matrix displays were constructed using these three dimensions and populated with data from each site report.

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

FINDINGS

HOUSING FIRST PROGRAM THEORY

Housing First logic model. This 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 Assertive Community Treatment (ACT) or Intensive Case Management (ICM) depending on the individual's initial needs assessment. Upon intake, a care plan is prepared by an enhanced ACT team or case managers. In this program, ACT teams are extended beyond the typical fidelity standards specifying a staff of social workers, a psychiatrist and a psychiatric nurse, to include a job development specialist and a primary care physician. In the case management model, staff broker with other providers in the community to provide additional support services.

Immediate changes in five areas believed to be critical in the recovery of the chronically homeless 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 use of alcohol or substances. A mediating variable of an increased subjective sense of wellbeing is predicted between increased participation in mental health treatment and reduced problematic drug use within 6-12 months. Similarly within this timeframe, access to community health services is predicted to result in increased participation in illness management and self-care. 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. The connection between reduced problematic drug use and increased participation in illness management, desired activities and social support are not clearly connected to recovery as the effects are predicted to interact and ultimately result in recovery measurable in six domains within 12-24 months. 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.

Critical ingredients as viewed by participants. Participants in the qualitative research identified four critical ingredients of the Housing First program.

Barrier-free housing. Across sites, the project component emphasized as being most essential is that of barrier-free access to housing. Housing is regarded as a starting point for participants, providing them with the stability and security they need to succeed in other aspects of their recovery. Several specific features of the Housing First model that stakeholders endorsed include the availability of an adequate rent supplement, the commitment to rehouse participants, the implementation of Housing First in the private rental market (ensuring appropriate quality and location), and the continuous involvement of staff during the participant's transition from homelessness to housed.

Housing First philosophy. While the access to housing allocated through the Housing First model is regarded as a significant strength, so too is the philosophical approach of the model, which promotes individual choice. Participants determine which apartment style and neighbourhood they prefer, they can decide to what extent they will participate

in treatment, and they have the freedom to continue to choose to engage in substance use. None of these choices limits the project's dedication to house them. Participants stated that this type of philosophical approach is critical in engaging consumers, promoting relationship-building between consumers and staff, and empowering participants to have independence and a sense of control. A Moncton stakeholder described the importance of individual choice by saying:

“Well, I think it is all about value. That you're valued wherever you are as a person. It's not [that] you have to be clean, sober, and straight and functioning as most of the world does to be accepted and valued. So I think that's a big part of it.”

High-quality, multifaceted care. In addition to aspects of the project relating to housing, stakeholders stipulated that the diverse clinical and social supports offered through the project are critical to its success. These services were described as being wide-ranging, client-focused and oriented toward prevention and recovery. The type of assistance that stakeholders reported being offered to participants includes access to a psychiatrist or primary care physician, as well as support with cooking, laundry, grocery shopping, paying bills, scheduling, organization, budgeting, family relations, social networks, employment and volunteering. Participants explained the importance of maintaining a low staff-participant ratio, offering services that are accessible to the client, providing care that is regular and frequent, building relationships with participants, and offering individualized, flexible support. In Montréal, both consumers and staff stressed that respecting the person's rhythm, choices and preferences is a critical element of the program. One service provider remarked:

«On pourrait faire « pour », mais moi j'essaie le plus possible de faire « avec » et au rythme du client. Il est là le défi. On est parfois pas mal plus pressé que le client. Personnellement, j'essaie vraiment de le garder en tête et d'essayer de me recentrer sur le rythme du client. J'essaie de ne pas vouloir plus que lui, d'y aller avec ses choix à lui.»

Lastly, participants identified mobility of care as being integral to the project's success. A stakeholder in Vancouver commented on the importance of home visits, saying “Coming to a person is definitely a sign of respect and it's a sign that you're seeking someone out. It makes people feel like they're worth finding.”

Quality and training of staff. Finally, stakeholders at all sites commented on the extent to which having the right staff contributes to the overall success of the project. A host of skills and personal qualities were described as being important, such as empathy, communication, flexibility and being non-judgmental. Stakeholders stated that staff need to be available outside regular work-day hours, need to develop relationships with participants and need to be comfortable working in an unstructured and unpredictable environment. Having a multidisciplinary staff make-up was also deemed important, as staff members with different professional backgrounds are better able to meet the diverse range of participant needs.

Redefining clinical practice. Montréal participants believed that redefining clinical practice is a critical ingredient to the program. Staff members need to redefine their role as trustworthy support figures rather than as experts. While they agreed on the importance of building trust with project participants, they had differing views on changing service providers and how to build trust. While staff changes can at times be irritating to consumers, a few service providers at the Montréal site argued that staff turnover can serve to facilitate the consumer's recovery and also prevent the participant from becoming dependent on his or her service provider.

These critical ingredients that were identified by participants are congruent with the Housing First logic model. Immediate access to housing and an array of services are concrete aspects of the model, while the Housing First philosophy and the quality of the staff represent more of the intangible but essential aspects of this model.

Early outcomes as viewed by participants. Participant engagement in treatment, acquisition of housing and establishing a community support network are the early outcomes viewed by participants, all of which are consistent with the Housing First logic model.

Participant engagement and housing. Participants reported that consumers are becoming engaged in the project, are developing trust and relationships with staff and fellow participants, are more functional and organized, and are experiencing increased social and family connections. As a result of this, they are benefitting from improved self-perceptions and an appreciation for life.

Housing. Participants reported that the project has been largely successful in obtaining housing for consumers and transitioning participants into housing. Observations of consumers maintaining their housing, despite histories of homelessness and complex clinical and social issues, were made by stakeholders across the various sites. Service providers in Montréal spoke of the participants' pride in having their own apartments and furniture, and in welcoming people into their homes.

«C'est une chose qu'ils n'ont pas eue depuis je ne sais pas combien d'années...C'est beau de voir ça. De voir leurs yeux briller...Oui et lorsqu'ils mettent leurs effets personnels, qu'ils se l'approprient...et nous accueillent dans "leur" endroit.»

Some consumers have also built supportive relationships with their apartment superintendent or other tenants. However, in addition to these early successes, stakeholders have also made note of a tendency for some participants to exhibit an increase in problematic behaviours after receiving housing. These behaviours, which have resulted in evictions and the need to transfer units, are often attributed to the isolation, loneliness and loss of routine and social networks that some participants experience in housing.

Establishment of a community support network. In addition to outcomes for consumers, stakeholders described the community capacity-building outcomes of the project. Stakeholders reported the establishment of contact and relationship building amongst various social service, clinical and community-based organizations. Such outcomes were considered beneficial to participants, as well as to be an important step towards creating a more resilient community that is better able to serve vulnerable members of the population.

Longer-term outcomes anticipated. Participants' expectations of housing stability and consumer recovery, in all its various manifestations, are also consistent with the recovery-oriented outcomes of the Housing First logic model.

Consumer housing and recovery. Participants foresaw a variety of positive outcomes for consumers. These outcomes included the development of independent living skills, improved mental health, the ability to find and maintain employment, and the achievement of long-term housing stability. Participants anticipated that consumers would be safer and healthier, and would experience increased community integration. In considering the futures of the participants involved in the project, participants emphasized the need to maintain housing subsidies and support services beyond the point of termination of the present project.

Changes in public opinion and a national housing strategy. Participants also believed the project could be successful in creating a paradigm shift around homelessness and mental illness, and in changing the service delivery system. They expressed the hope that the spirit of the project could foster community acceptance for people experiencing homelessness and mental illness, and could change the opinions of landlords and other community members. The findings of the project were expected to be put to use in the creation of a national housing strategy and service delivery framework, which consumers believed should emphasize partnerships among various service providers to allow for a more comprehensive continuum of care for clients. Participants also embraced the idea that a Housing First model could become more widespread, offering consumers barrier-free access to housing and a diverse array of support services.

WHAT WORKED WELL AND WHAT WORKED LESS WELL IN IMPLEMENTATION

A summary of the strengths and challenges revealed by the fidelity evaluation can be found in Table 9.1 in Appendix 9. A summary of what worked well and worked less well in the implementation according to the qualitative evaluation can be found in Table 10 in Appendix 10.

WHAT WORKED WELL

Strengths: Fidelity evaluation.

Overall, 71 per cent of the fidelity scale items are rated as higher than three on a four-point scale, indicating a high level of fidelity to the Housing First model. The strongest fidelity findings are in 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 each of the sites. 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.

Factors that facilitated implementation: Qualitative evaluation.

Site factors. The size and culture of the community was thought to be a factor that helped implementation in Moncton, where participants explained that the small size of the community contributed to project staff's ability to contact and collaborate with existing community service providers. In the small community, information is easily transmitted amongst professionals, the public and potential participants. This has helped word of the new program spread quickly. Beyond the size of the community, Moncton stakeholders also cited the strong Acadian culture as facilitating implementation. The spirit of collaboration and collective effort that is central to the At Home/Chez Soi project has been fostered by the Acadian culture of the region, which is communal in nature.

The *strength of existing services in the community* was another helping factor. At the Winnipeg site, participants explained that existing services in the community have facilitated the implementation of the At Home/Chez Soi project. The city of Winnipeg is described as having many useful resources, including vocational training, food and drop-in programs, all of which benefit the project's participants. A stakeholder commented that "we've just scratched the surface" of the services available within the community. In Toronto, participants mentioned the importance of recruiting consumers in such a manner that allows them to maintain existing service relationships with established community service providers. Similarly, in Montréal there is an important network of organizations devoted to homelessness and substance use. Over time, collaboration developed between project programs and the major shelters and this facilitated recruitment of participants. Assisting consumers with the creation and maintenance of rich service environments is seen as facilitating implementation.

Site-specific programs that address the needs of racialized groups were also mentioned as a helping factor. Participants at sites with programs specifically designed to account for the needs of racialized participant groups noted how important this type of provision is to the success of the project. In Toronto, there is an ethnoracial ICM model in place, which makes use of an anti-racist/anti-oppression framework. In Winnipeg, the Aboriginal Lens Committee provides an Aboriginal context and perspective to the services offered by the overall At Home/Chez Soi project. Stakeholders stated that having these types of site-specific programs available is critical to engaging racialized consumers and ensuring their success in the project.

Organizational/team/service factors. Leadership was seen as helping implementation. Stakeholders commonly referred to leaders as a resource, with that resource being critical to project implementation. Site Coordinators, team directors, and other program leaders were cited by stakeholders as possessing skills and attributes that facilitated implementation. Effective leaders were those considered to have strong decision-making abilities, to provide clear direction, to foster an environment of shared learning and respect amongst staff, and to have extensive experience working with various consumer populations. As was discussed by key informants at the national level, successful implementation is facilitated by Site Coordinators who have a strong understanding of the project-wide logic model, and can be relied on to move their site towards the implementation of that model. These national key informants reported the importance of having neutral, skillful Coordinators with a strong "big picture" understanding of the overall project.

Beyond the importance of effective leadership, having a *strong staff team* was also described as benefitting implementation. Stakeholders identified the importance of having staff with the right combination of technical and

interpersonal skills, and noted the value of staff knowledge of mental health and addiction issues, as well as assessment skills, commitment to the project and participants, and openness, respect, and adaptability. National key informants confirmed that having staff with the right philosophy, values and skills is critical to project implementation. Stakeholders also recognized that a key strength of staff teams in the project is the diversity that is found among team members. Multidisciplinary team make-up is regarded as critical in adequately responding to the wide-ranging, complex needs of participants. Team diversity was described as fostering cross-team learning and sharing, breaking down hierarchical relationships within teams, and providing participants with expertise and information in a wide variety of areas.

In addition to the advantageous nature of team diversity and the qualities of individual staff, stakeholders made note of *team cohesion and positive team relationships*, both of which were deemed to facilitate project implementation. Montréal stakeholders emphasized the importance of staff stability, which allowed service providers to integrate new approaches, practices and tools. Activities like structured meetings, formal training, all-team events and meetings, and sharing project office space were all considered to benefit the team working environment. This environment was described as supportive, open, flexible, cooperative and characterized by trust, mutual understanding and shared commitment to project values. Stakeholders viewed cross-team cohesion and positive relationships among staff as being critical to the successful implementation of the project, which requires staff to do difficult and taxing work. Likewise, national key informants made mention of how vital having a supportive organizational culture is to the project.

A final organizational/team factor that stakeholders identified as facilitating implementation relates to the projects' *organizational structure and governance*. Stakeholders at the Toronto site described this factor in most detail, stating that project governance structures are critical in defining roles and responsibilities, and allowing for collaboration, partnership building, effective communication and conflict resolution. Toronto stakeholders specifically mentioned the important effect on implementation that the site operations team (responsible for creating a memorandum of understanding), local advisory committee and various work groups had. Montréal stakeholders similarly highlighted governance successes. At the national level, key informants affirmed how valuable it is to have a clear organizational structure so that staff can understand their roles in relation to one another, as well as the role of project components in relation to one another and the overall project logic model.

Mental Health Commission of Canada. Participants considered the MHCC to be responsive, fair, generous and supportive. Instances of communication between sites and the MHCC were characterized as being positive and productive. *Resources provided by the MHCC* that were thought to facilitate implementation included funding, practical guidance and training opportunities, which were described as being ongoing, in-depth, and relevant to the treatment of a wide variety of mental health issues. National key informants commented on the process of identifying international experts who have been able to contribute their expertise to training programs offered to the various sites. A stakeholder at the Toronto site commented on the resources offered by the MHCC by saying,

"...We got lots of training, lots of money, nobody has that kind of [money and resources]. The opportunities that they've had around ability to go to conferences, ability to learn together, ability to attend courses—they had a whole month of orientation nobody has had."

Participants at the Toronto site also detailed the effect that the visibility and *on-site presence of the MHCC* has had on implementation. They explained that the Site Coordinator has been able to advocate for the Toronto site at the national level and has facilitated relationships between the Toronto site, Toronto community partners and the MHCC. Stakeholders considered the co-location of an MHCC representative onsite with service teams to have a positive impact on the Toronto site, providing opportunities for information sharing and problem solving.

Partnership factors. Many of the important partnerships described by participants were at the local, community level. Participants said that these local partners have been crucial in contributing expertise and experience to the At Home/Chez Soi project, and have increased the project's capacity to integrate into community networks of supports and services. The long list of different partnerships that have been established by the various sites include those

with local business owners, police, hospital staff, community mental health teams, shelters, meal providers, churches and missionaries, the United Way, and mobile crisis teams. Some of these partners have played fundamental roles in assisting the project in implementing its main objectives. For instance, the United Way of Greater Moncton and Southeastern New Brunswick is described by stakeholders as being crucial to the implementation process, as it has coordinated access to housing for project participants at the Moncton site. Across sites, participants explained that having a diverse group of partners has been critical to providing a comprehensive continuum of care to participants. Participants conceptualized the At Home/Chez Soi project as a bridge, bringing together the host of community services that had previously been operating in a much more fragmented manner.

In addition to the many local, community partnerships, the At Home/Chez Soi project has partnered with various *government agencies and departments*, which has facilitated the project's implementation. These partnerships have enhanced the project's ability to secure consumer access to housing units, mental health and homelessness services, and government income supports. In Vancouver, stakeholders described working collaboratively with the Ministry of Social Development, which has led to increased consumer access to services, reduced wait times and less need for project staff to conduct follow-ups. Winnipeg participants mentioned that Employment and Income Assistance staff are represented at monthly At Home/Chez Soi site meetings, and that a partnership has developed with Child and Family Services, resulting in some participants achieving increased access to their children. At the Moncton site, partners include the Department of Health, the Department of Social Services, the Department of Social Development (from which the majority of participants receive social benefits), the Royal Canadian Mounted Police and the Department of Post-Secondary Education, Training and Labour. When reflecting on these partnerships, stakeholders stated that partnering with these agencies and departments has enabled greater transfer of information and has increased the project's capacity to become integrated into the local mental health system, as well as to have an impact on it. At the Toronto site, participants emphasized the importance of the housing work group forming a partnership with representatives from Ontario Works (OW) and the Ontario Disability Support Program (ODSP). As a staff member observed, "We're getting people into ODSP at an amazing rate because we have senior reps from ODSP and OW sitting on the housing working group." A Toronto participant also commented on the importance of the partnership, saying,

"I figure they have a really good relationship with ODSP; seems you get things done quite efficiently with the ODSP workers. Like as if they, they have some professional courtesy amongst them or something because, um, I have been doing really well with ODSP since I have been with the program."

A final partnership factor that participants regarded as having facilitated implementation is related to the formation of partnerships with local landlords and landlord associations. Partners described the importance of fostering positive relationships between the project staff and landlords. In Montréal, the housing team developed outreach and retention strategies with clinical service providers, consumers and superintendents. It was noted that among the forty-plus landlords (for 117 participants), personal knowledge of mental health and homelessness sometimes played a part in the landlord's decision to participate in the project. To this end, in Vancouver, landlord appreciation and education events have been organized. Stakeholders across sites expressed the value of collaborating with landlords, as this type of collaboration can make landlords more tolerant of participants as tenants, and can make landlords more willing to consult with service team members to resolve issues, rather than to evict a consumer.

Participants also described the value of *partnerships with consumers* for program implementation. Participants at several sites described the emergence of peer-driven initiatives that have made important contributions to the implementation of the project. According to participants, fostering partnerships between the At Home/Chez Soi project and its participants is of significant value, and is seen to have increased the legitimacy of the project. Social get-togethers, peer-support programs for individuals with substance use issues, participant-produced newsletters, and participant-led focus groups on evictions are all examples of consumer involvement in project implementation. Stakeholders considered these types of initiatives to be key to the development of positive relationships between staff and participants, and amongst consumers themselves. Stakeholders reported that consumers help their fellow consumers by providing them with information about the services available in the community and, similarly, can act as

a resource for staff by offering them insider information about community resources. The Toronto site has tapped into the concept of participants-as-resource by forming a Consumer Caucus comprised of 22 people with lived experience. The Caucus is represented on the Site Operations Team, the Local Advisory Committee and various other project working groups and local governance structures. The value of the Caucus is described by stakeholders as significant, having provided the project with in-house experts and grounding the project in the participant perspective. People with lived experience have also been involved at the national level, as they have been hired to assist in the fidelity assessment process at each of the project's sites.

A further way in which consumers are proving to be valuable to the implementation of the project is through working and volunteering for At Home/Chez Soi. In Winnipeg, participants reported that consumers who have made progress toward recovery are contributing back to the project by volunteering at food kitchens and other community agencies, and at the project service arms. A community partner of the project, Manitoba Green Retrofit, has also reportedly hired consumers as employees for project-related work tasks. Similarly, in Vancouver, consumers are hired as employees at the congregate site, where they complete tasks such as meal preparation and laundry. By getting involved in the project through volunteering or employment opportunities, consumers are contributing to the implementation of the project by providing needed services, as well as by making advancements toward their own individual recovery, thereby affirming the success of the project. A final observation made by stakeholders at a number of sites was that implementation has been facilitated by having a team of staff composed of some individuals with lived experience. Staff members with lived experience are reportedly better able to build trust with participants, and are able to relate and empathize with the struggles participants face. Service providers in Montréal reported that the peer support worker is well-integrated into the ACT team. He was able to bond with consumers and defend their interests; he receives biweekly support and supervision from a provincial training and support group for peer support workers. Furthermore, respondents noted that integrating a peer support worker into the ICM teams would be beneficial. The involvement of these staff members is seen to benefit the implementation of the project by facilitating the engagement of consumers and the establishment of positive consumer-staff relationships.

WHAT WORKED LESS WELL IN IMPLEMENTATION

Challenges: Fidelity evaluation

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 two of the sites. Offering 24-hour crisis response services was noted as a challenge at the Moncton site, and mobile crisis services in the community were enlisted to provide overnight support. 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.

By far, the most challenges were observed for the Service Array domain. The items of psychiatric services, substance use 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 eight of 12 items that were challenges; the scores were higher for ICM teams on only two of the 12 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.

FACTORS THAT HINDERED IMPLEMENTATION: Qualitative evaluation.

Site factors. Although Moncton participants cited the advantages of the *small size of the community*, a perceived disadvantage of the small size of the community for staff has been when certain information about the project or consumers is shared. For example, in some cases, landlords shared information about difficult consumers in the network of landlords, and this made it more difficult to house these individuals. The small size of the community also contributed to consumers sharing information about the program, leading participants to expect that they will receive

equivalent services as others. Similarly, the sharing of information among landlords led them to negotiate for similar compensation related to necessary repairs at their properties.

A universal barrier to program implementation across all sites was the *lack of affordable and available housing*. In Moncton and in the rural region, it was stated that there was a limited selection of housing from which to choose. Similarly, Winnipeg reported difficulties housing participants, with some individuals waiting up to five months for housing. Finally, Toronto program staff cited the scarcity of affordable housing units, particularly in downtown Toronto, as hindering program implementation. Some consumers have to wait three to four months to be housed. Staff noted that it was particularly difficult to find supportive housing options, which is a concern for clients who prefer supportive housing but are “forced to live independently” (Toronto report, p. 26). These findings are consistent with fidelity data that indicate that challenges regarding housing choice and housing availability hinder implementation of the Housing First model.

In addition to housing shortages, a *lack of public transportation* was also viewed as a significant barrier for Moncton consumers to get to appointments to receive health and social services, or to visit the food bank. The lack of transportation also made it difficult for consumers to maintain relationships with family and friends, leading to social isolation. Also, in Montréal, many housed participants do not have telephones. This results in difficult communication, missed house visits from service providers and increased isolation.

Although programs designed to account for the needs of racialized participants were cited as a major resource for participants, there were also some unique implementation challenges related to *addressing the needs of racialized groups*. In Winnipeg, social isolation was cited as a major concern for consumers coming from families of Aboriginal backgrounds where they lived with or very close to extended family. Staff suggested that the project should use more congregate-style housing units to address this cultural issue. Toronto cited unique challenges of hiring and training culturally competent staff to accommodate the needs of Aboriginal participants in the program. Key informants in Toronto also expressed difficulties meeting the cultural and linguistic requirements of their diverse population. For example, they do not have Korean-speaking staff to assist Korean participants, requiring them to tap into translation services outside of what they already have.

Organizational/team/service factors. Stakeholders at the Winnipeg, Toronto and Montréal program sites noted a general *lack of contact and cohesion between teams* as a factor that hindered implementation. Winnipeg staff desired more opportunities for informal communication between teams (e.g., in-person conversations as opposed to formal communication via phone calls); and Toronto staff expressed frustration with the fact that housing and support services teams occupy different sites:

“...I think the real challenge is that the housing folks are not embedded with us, and I think that that’s a real concern. We missed an important opportunity that we didn’t realize we were missing.” (Toronto report, p. 18)

Winnipeg staff noted significant challenges as a result of landlords, service teams and research partners being separated and compartmentalized. Because each service arm is independent, interagency collaboration has been a challenge. Toronto service providers also expressed a lack of collaboration between teams, with some informants reporting early tensions between support teams due to competition for housing and the perception that teams were being compared to one another on project outcomes. Housing providers and clinical teams in Montréal had differing interpretations of recovery. Whereas housing providers viewed moving from one apartment to another as part of the recovery journey, service providers felt that remaining in their apartment was an important learning experience for participants. This, coupled with tensions related to the pace of placement into housing and disagreement over which service teams should be responsible for managing housing crises, complicated relationships between these teams.

Staff workload issues and caseload size were expressed as a major concern at each program site. The required travel time between staff offices and participants’ homes was deemed a significant burden on service teams in Montréal and Toronto. With housing spread out across the city, providing follow-up involved a great deal of travel time (upwards of

two hours per hour-long house call). Key informants in Moncton and Toronto emphasized the importance of self-care and wellbeing for staff, suggesting that measures be taken to ensure that service providers work regular hours and have opportunities to debrief on their concerns. Consumers in Winnipeg also noted that staff members are overworked, which has led them to try to limit the demands they make on staff. Similarly, consumers in Winnipeg expressed concern that the ratio of consumers to staff was too high, resulting in them not being able to get the same level of one-to-one attention that they had received earlier in the project. A general consensus among Winnipeg stakeholders was that all teams found the workload light at the beginning of implementation, but then it became heavy, and at times excessive, as the number of participants increased. Montréal ACT and ICM teams struggled with how to reconcile a recovery approach with the heavy workload demands. Confronted with numerous tasks, service providers had to build trust with participants and offer them intensive accompaniment at the same time as they were dealing with team reorganization and considerable staff turnover. Vancouver staff found the rate of recruitment to be too fast and felt they were unable to assess and house new participants. Toronto housing staff mirrored this attitude, acknowledging the immense pressures placed on support staff to handle the rate of intake for new consumers while supporting existing consumers and helping them to maintain their housing. Likewise, Toronto support teams recognized the challenges faced by housing staff in finding affordable and accessible units for consumers. Service providers also noted a lack of some crucial staff resources as a barrier to implementation. ACT and ICM team members in Vancouver described the difficulty in not having established program protocols prior to implementation, while staff in Winnipeg has been challenged in trying to house new participants while having only limited information on a participant – often only a name and a birth date. The large number of solvent-abusing participants in Winnipeg has also required adaptation on the parts of the service team, who were not equipped to deal with the specific challenges raised by this issue.

Stakeholders across sites noted that the *diversity of consumer needs and functioning* has made program implementation difficult. For example, service providers in Vancouver expressed that the project design makes it impossible to transfer participants between service teams and housing types, even if a different model would be more appropriate to the needs of clients. A few respondents indicated that the study design is not practical from a “real-world, on-the-ground perspective” (Vancouver report, p. 28). Similarly, concerns were raised by stakeholders in Toronto that teams were receiving participants with levels of need that were incorrectly matched with the ACT or ICM models.

Stakeholders also expressed concerns that some important service programs are currently lacking. For example, stakeholders in Moncton stated that program capacity needs to be developed in several areas, including addictions treatment, vocational and educational support, peer support, education related to food preparation and nutrition, and psychiatric consultation. In Winnipeg, consumers expressed concern with the lack of after-hours staff support to assist them with crisis situations and landlord issues.

Consumers expressed *frustration with some staff practices*. In Moncton, some consumers were dissatisfied with home visits due to the variety of people dropping in to visit them. Likewise, some consumers in Montréal viewed home visits as unnecessary and that they were “being checked up on.” Others were frustrated with the volume and repetitiveness of questions asked by interviewers. According to stakeholders, encountering several staff members can be emotionally exhausting for participants.

Mental Health Commission of Canada. While the MHCC was generally seen as a positive factor in program implementation, there were mixed views on MHCC training. Service providers in Winnipeg, for example, believed that more sensitivity training was needed (e.g., Aboriginal communication styles and body language), as well as training on how to deal with persons at risk for suicidal behaviour. Housing staff pointed out that the site was not prepared for the high volume of consumers moving out and needing new housing situations. Staff suggested that there could have been more preparation or training in terms of this possibility. Key informants at the national level address this issue, stating that a large challenge to implementation was the unevenness of expertise of the teams at different sites, with some sites requiring more technical assistance than others. National key informants also expressed difficulties designing training that is relevant to all sites when the groups are in very different places in terms of “local/social/systemic capacity realities” (National key informant summary report, p. 3). Finally, key informants acknowledged that it is difficult for busy

team members to find the time to participate in training and improve their practice approaches in a way that does not make their already stressful jobs even more stressful. Another issue brought forth by Montréal respondents was the level of decision making. They understood the need to standardize across the sites but questioned site responsibilities since they often consulted the National team to resolve problematic situations. For some participants in Montréal, this resulted in a lack of interest or ownership of the project among team members.

An issue of central importance across sites was *worries about program sustainability*. In Vancouver, respondents expressed concerns about the lack of conversation regarding building national consensus to sustain project gains and to advocate for a national housing strategy. Similarly, Winnipeg staff reported feeling uninformed on the process for keeping the program going after the At Home/Chez Soi project is complete. Staff reported being particularly worried about what will happen to participants when they no longer have access to housing subsidies. According to staff, participant housing costs will easily triple without the housing subsidies. As one staff member noted, “You might as well cancel the whole program” (Winnipeg report, p. 22). Toronto staff reported feeling equally “in the dark and uninformed.” Further, they felt a critical need for knowledge dissemination from the MHCC around steps being taken to ensure that clients are not, as one client described, “kicked back into the streets” after the At Home/Chez Soi project is complete (Toronto report, p. 20).

Partnership factors. *Less than ideal local, community partnerships* were noted as a factor that hindered implementation in the sites. Stakeholders in Moncton believed that community partnerships could be further developed. For example, it was noted that agencies such as the Rotary Club, city councils, the Women’s Progress Club and city businesses could be good resources for the program, particularly around the important issue of consumer employment. Moncton staff stated a need for better collaboration and communication with health care providers in the community. For example, staff indicated that when consumers are hospitalized, obtaining information about consumers from the hospital is difficult due to confidentiality concerns. Hospital staff have been largely unaware that the At Home/Chez Soi staff are serving as consumers’ primary case managers in the community. The lack of availability of services or partnerships with other services is consistent with the relatively low ratings of items on the fidelity domain of Service Array.

There were also challenges related to partnerships with government agencies. Stakeholders in Winnipeg described the challenges presented by some external institutions and organizations. For example, the housing team must deal with landlords and Manitoba Housing yet it is seeking to deal only with landlords, with no involvement from the Residential Tenancies Branch. Another challenge described by stakeholders is that when participants entered the At Home/Chez Soi program, the supports they may have been receiving from other agencies, and upon which they depended, were withdrawn. Informants reported that service delivery to participants is also affected by external structures. For example, Indian and Northern Affairs only recognizes and will only allow certain drugs to be prescribed. Consumers who need a specific drug that is not covered by this agency cannot receive it. Stakeholders in Moncton also reported difficulties communicating with certain government agencies about program participants, particularly with health care, and court and legal personnel. Staff suggested that it would be helpful to educate legal personnel about the At Home/Chez Soi program so they may better assist consumers to handle any legal issues.

Challenges related to partnerships with landlords were also noted. While landlord relationships were reported as being generally positive across sites, there were partnership issues that certainly hindered program implementation. First, stigma from some landlords was reported as being an issue in Vancouver and Toronto. Program staff in Moncton viewed some landlords as scrutinizing At Home/Chez Soi consumers more closely than their other tenants, while a number of staff members in Toronto noted that consumers often get turned down for housing after meeting with landlords – perhaps based on race, homelessness and/or mental health status. Second, program staff have had to work hard to sustain and repair relationships with landlords, particularly after they have had to evict At Home/Chez Soi participants. A common problem cited by Moncton staff as leading to a number of evictions is the introduction of “outsiders” to the apartments who visit or even move in with program participants.

“... As a result of relationships developed while they were homeless, participants find that their apartments often serve as meeting grounds, with a large influx of people coming in to visit and even sometimes taking it over.” (Moncton report, p. 28)

Winnipeg staff have tried to keep landlords satisfied and engaged in the program. However, it has not been possible to keep all of the guarantees that initially attracted landlords to the program. This, coupled with the problems they have had with some At Home/Chez Soi clients, has caused several landlords to leave the program in recent months, “taking their units with them” (Winnipeg report, p. 12).

While partnerships with consumers were viewed as something that helped implementation, *consumer involvement* remains an issue across the sites. In Montréal, stakeholders are unaware of the activities of the Conseil ex-pairs, and regret the general lack of communication about the role of peers in the project. The fidelity data revealed participant representation in the programs to be the lowest rated of all the fidelity items. This indicates that all of the sites need to take steps to ensure more participant representation in the programs.

INNOVATION: Fidelity and Adaptation

The approach undertaken in this project was informed by current thinking about the implementation and evaluation of complex population health interventions (Hawe, Shiell, & Riley, 2004), which emphasizes adherence to the fundamental principles and philosophy of the program rather than insisting upon conformity with all of the details regarding its delivery. This leaves room for adaptation of the intervention to the special characteristics of the local context and for innovative additions and modifications that remain true to the overall program theory. This was the conceptual approach that informed our thinking about implementation in the At Home/Chez Soi study. The recovery orientation, with its emphasis upon choice and person-centred care, and a commitment to the speedy provision of housing with no preconditions, were expected of all programs. One of the goals of the implementation evaluation was to ascertain what other elements seemed to be critical and where there was room for different practices and protocols.

Fidelity. As shown in Table 9.3 in Appendix 9, which describes the mean scores of each site for each domain, a generally high level of fidelity to the Housing First model was achieved within the first 12-18 months. With the exception of the relatively low scores for the Service Array domain, these data indicate that, for the most part, programs were able to function in a manner that was in keeping with the recovery-oriented philosophy and the practices associated with Housing First (i.e., there was a commitment to harm reduction, the separation of housing and services, and the provision of permanent, affordable and integrated housing). There is room for improvement, but all cities successfully fulfilled the fundamentals of their mandate.

Contextual influences and program adaptations. All of the sites experienced contextual factors that influenced implementation and led to program adaptations. Most of the contextual influences concerned the community and the nature of the population served by the programs.

Community influences. Restricted access to quality rental units is a challenge for all of the sites. In Vancouver, there is a very low vacancy rate for bachelor apartments, and these units cost nearly double the shelter allowance for people on social assistance. Housing in Vancouver for low-income people consists primarily of large congregate facilities, including Single Room Occupancy (SRO) hotels. Winnipeg also has a low vacancy rate of affordable rental units that are concentrated in the city’s downtown core and north end. Toronto has a low vacancy rate, a scarcity of rental units in the downtown area, and long waiting lists for supportive housing. Similarly, due to the small size of the community, Moncton has limited rental units available for participants, both in the city and in the surrounding rural area. Landlord issues are a related contextual factor. In Winnipeg, racism, combined with mental health issues and substance and solvent use, impacts on Aboriginal people’s access to rental units.

“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 racism and systemic discrimination.” (Winnipeg report, p. 3)

In Toronto, a small number of landlords own the majority of rental units in the downtown area, so it is very important for the project to cultivate positive relationships with these landlords. These housing conditions—low vacancy rates, geographic concentration of affordable rental units, and landlord issues—constrain consumer choice over housing, which is a key principle of Housing First.

“Sometimes when you are trying to house people and you don’t always have time to find the right place, it is a place. And that’s not the Housing First principle. I know that it’s supposed to be choice but in a small market you don’t have that choice, you’re limited by affordability, by whether the landlord is on board with the program, you’re limited by location, participants where they want to live, sometimes they want to live in a certain area and there’s no place there, well sometimes that choice is certainly taken away. So it’s not always choice first, sometimes it’s practical.” (Moncton report, p. 41)

While challenging, Toronto’s Housing Team has developed several *strategies to increase access to rental units* in the downtown area or wherever consumers wish to live. This includes having a package of resources in addition to the rent supplement (a \$1,500 budget for furnishings and move-in costs, last month’s rent, a vacancy loss fund, insurance to cover damages and a fund for temporary accommodation), approaching landlords about future rentals, keeping an inventory of rental units and working with service teams to look for units. An additional strategy used later was helping service teams access units through the TCHC market rental website.

Another challenge to implementation is the service environment. In Vancouver, Winnipeg and Moncton, Housing First, ACT, and ICM did not exist prior (or were relatively recent) to At Home/Chez Soi. This created challenges in developing a commitment to Housing First principles beyond the project.

“... 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).” (Vancouver report, pp. 11-12)

Also, in the rural area of the Moncton site, there were few resources available for consumers to use. In contrast, Toronto has a richer service environment, with staff from different programs experienced in Housing First, ACT and ICM. Toronto formed a Referrals Working Group with community stakeholders to assist with participant recruitment. While this approach may have initially led to delays in recruitment, in the longer term it has been a very powerful approach.

“... a key component of the Toronto site that I am particularly proud of and think has been very successful is our approach to referrals which I think gets us the best quality research and is the best way to protect the individual so as to ensure that they are not taken away from services and we get the best input of services from the community into our program.” (Toronto report, p. 29)

Another contextual influence noted in the Winnipeg and Moncton reports concerns the *invisible or hidden nature of homelessness*. In Moncton, this meant that people who are homeless are not necessarily living on the streets, while in Winnipeg it meant that the large homeless population could obscure the fact that there is an even larger, hidden homeless population. Transportation issues were also noted. This was particularly evident in the rural area of Moncton, but the Toronto report also noted that staff spend considerable time in transit in the nation’s largest city. Finally, two positive influences noted only in the Moncton report were the sense of community that is associated with the Acadian culture and the active involvement of family members, particularly with consumers living in the rural area.

Nature of the population. One contextual factor that has influenced program implementation at all of the sites is the *complex needs of the population served by the programs*. In Vancouver, many of the participants have addictions, substance use and health issues. In Winnipeg, there is a substantial population of participants who have not been well served by the mental health system, whether owing to substance use, or because of their Aboriginality. Toronto also has many consumers with complex needs, “often those who have not been successful elsewhere” (Toronto report, p. 31), as well as a previously underserved population from diverse cultural-linguistic communities. Due to the small population, Moncton has an ACT program, but not an ICM program, which means that it serves a population with a wide range of functioning. This *high level of complex needs puts stress on the staff of the programs*. The issue of the 1:20 staff to consumer ratio in ICM programs was particularly noted in the Toronto report as being too high.

"I honestly think that the caseload size is the most significant challenge for us and until we address that we won't be providing anything significantly different than we are now." (Toronto report, p. 32)

Staff members in Toronto spoke of experiencing burnout and "compassionate fatigue," with some having to take sick leaves or resigning from their positions (Toronto report, p. 33).

All of the sites *modified their services to adapt to the demands of the population with complex needs*. In Vancouver, staff were trained in harm reduction and substance use treatment, and they hired an addictions specialist for their ACT team. Winnipeg initiated a Solvent Network to address the needs of solvent-using consumers and developed strategies around housing for these consumers (i.e., having only two to three solvent-users in one setting), as well as developing an Aboriginal Cultural Lens Committee to form culturally sensitive programs for the Aboriginal population. Toronto created a Clinical Support Team, comprised of the three Team Leads and one of the Principal Investigators, to problem solve around the complex needs of consumers. They also hired Peer Workers from diverse cultural backgrounds and used translation services for consumers from cultural-linguistic communities. Moncton had to modify the hours that project staff were available to consumers and to use the services of a consulting psychiatrist since the ACT team had a Clinical Director who was a family physician, not a psychiatrist. The Montréal site collaborated with a shelter to provide temporary housing for participants who felt overwhelmed with the stress of living in their apartments. Additionally, Montréal's housing team developed new tools including: (1) a list of vacant housing, (2) a descriptive data form for each apartment, (3) a quality evaluation checklist, (4) a form to calculate the percentage of rent to be paid, and (5) an inventory of housing photos and their geographic location.

Local innovations to the programs. There are many examples of innovative Housing First practice in the five sites and they range from a very different approach to housing, as illustrated by the Bosman congregate living option in the third arm of the Vancouver project, to more fine tuning of the existing model, as illustrated by the bilingual nature of the Montréal and Moncton service and housing teams. The following highlights only one of the many possible examples of major innovations for each site that have occurred as the various programs have been implemented.

In Moncton, the geography of the region stimulated creative thinking about how to deliver Housing First in rural areas. A small team of two to three staff members is located in a satellite office in the midst of an adjacent rural area, some 40 minutes away from Moncton. The ability to collaborate closely with the ACT team in Moncton has allowed for a sharing of expertise and resources. Members of both teams participate in morning meetings via teleconference on a regular basis. When indicated, specialists on the ACT team are available for consultation with staff and/or for visiting rural clients. "If they perceive that they need a home economist to do some teaching, then the home economist will go out" (Moncton report, p. 34). It has taken some effort to make sure that the rural team feels integrated with the rest of the program, but little things count, like making sure that visitors from the national team attend meetings held in both sites. The study design was modified for this pilot project to be quasi-experimental with a comparison group drawn from the same settings where the participants live and receive service. Knowledge about the characteristics of this unique sub-sample and the innovative service delivery model will add to the sparse literature on the effectiveness of interventions for rural populations.

In Vancouver, the successful recruitment of landlords and apartments in a very tight rental market has been accomplished by a small housing team. One of the innovative additions they devised, that has also been used in several of the other cities, is to hold landlord appreciation events. These events have been used to strengthen the relationships between the program and the private landlords who have agreed to provide units for participants. They recognize this group as a key player in the project and underline for service staff that they are allies rather than outsiders from whom they need to protect the participant. It is also important to reinforce with the landlords that the participants are potential tenants rather than potential problems. "We have to get out of these mindsets of seeing [homeless] people as hostile enemies...And we have to think how to work together to get this done" (Vancouver report, p. 24). The inclusion of groups of landlords as a part of the project is not an explicit component of the Housing First model, but it is a practice that has been found to be helpful in the Canadian context.

In Toronto, because of the highly diverse make-up of the population, all of the services are challenged to meet the cultural and linguistic requirements of various ethnoracial populations. “We have clients that speak different languages” (Toronto report, p. 35). A program-wide innovation is a Housing First ethnoracial ICM program, the third arm of the Toronto project that combines the Housing First philosophy with an anti-racism/anti-oppression (AR/AO) framework. It is focused upon the engagement and support of ethnoracial participants experiencing homelessness. One aspect of this innovative program, which is provided by Across Boundaries, is the hiring and retaining of professional staff members who are from the ethnoracial backgrounds of the participants. Having supervisory and administrative staff with relevant experience helps to create a culture where issues of race and oppression can be addressed. Frontline staff can act as role models for participants on how to name and respond to discrimination, as well as bring their knowledge about the experience of living in the same communities.

“If you are not able to name the issue and if you chat with the client about their experiences then you are not really addressing it...” (Toronto report, p. 10.)

Evaluation of this innovative adaptation includes a supplementary fidelity scale developed to assess the implementation of the AR/AO framework. A focus upon the characteristics of the human resources within the program is not always included in best practice fidelity measurement.

This innovation and the hiring of Aboriginal staff for the Winnipeg programs draw attention to this important dimension. In Winnipeg, the majority Aboriginal population receives services within a culturally sensitive context. In addition to this strong cultural component in their service arms, Winnipeg has created an exciting, new supplemental Housing Plus program, operated by the Ma Mawi Wi Chi Itata Centre. This program performs many of the tasks that are crucial to providing housing (e.g., move-ins, move-outs, inspections and housing condition reports). It arranges for furniture and personal needs goods (e.g., pots and pans, toiletries, etc.) which it distributes from its warehouse. It also is very involved in keeping the landlords happy with the program through its maintenance and repair services. The rapid response to outfitting and housing participants has been accomplished through collaboration with Manitoba Green Retrofit. This program has demonstrated a recovery orientation through its hiring of persons with lived experience. It also has an economic development role in the local community by sourcing locally produced bedding and furniture from Winnipeg companies, rather than dealing with large chain stores. Although conceived to respond to At Home/Chez Soi needs, this innovative work program has clear applicability to other housing providers and now serves a wider group of agencies.

CROSS-CUTTING THEMES AND LESSONS LEARNED

Developing a Broadened and Deepened Understanding of Service Philosophy: The Meaning of Choice Over Housing and Treatment Options

A common theme underlying results from all three sources (fidelity assessment, qualitative implementation evaluation and national key informant reports) relates to how the teams are developing a broadened, deepened understanding of the service philosophy surrounding the meaning of choice over housing and treatment options. Most ACT and ICM teams were rated highly on this domain. The consumer perspective described in the implementation evaluation reports affirm that adopting harm reduction and eschewing treatment contingencies is valued by participants as reflecting unconditional support. Choice over housing is also recognized as fostering a sense of self-esteem and incipient control over other aspects of life beyond housing. Both the fidelity and implementation reports suggest, however, that assuring housing choice in practice may require broadening the options available to participants to include not only scatter-site apartments, but also supportive, social, shared or congregate housing options for those who would prefer these. The narrative interviews early findings report suggests, for instance, that such options may be preferred by individuals concerned about isolation, or about having very high support needs. The fidelity reports remind the teams, however, that providing such options does not obviate the need in principle to maintain separation of the housing and support aspects of the model. They raise the question, for instance, of how a congregate model (e.g., the Bosman hotel in Vancouver) will continue to provide housing and support for a resident requiring rehousing. While upholding the value of choice over treatment options, the fidelity reports at the same time emphasize that consumer directedness in practice should not imply a laissez-faire approach to engaging participants.

In terms of lessons learned, the fidelity reports recommended that teams strengthen their collective capacity to integrate motivational approaches more fully into day-to-day practice. Furthermore, practitioners could become more proactive about teaching and/or supporting alternative approaches to illness management and recovery, especially for those people whose unmanaged symptoms or challenging behaviours may jeopardize their housing situation. The national key informant interviews affirm both motivational interviewing and alternative illness-management approaches as a priority for the ongoing training, technical assistance and fidelity measurement strategy coordinated by the Mental Health Commission of Canada. Finally, the fidelity reports suggest that, by becoming more focused on active engagement of consumers (and avoiding a focus on apartment inspections), rehousing rates could be minimized. Our discussion surrounding housing choice suggests that the focus of the Housing First model on independent, scatter-site apartments could be broadened to include other options. However, these should be developed truly in the spirit of choice, and offered to those who would prefer them, in a way that respects the principle of separation of housing and support, and is able to provide continuity of housing and support for individuals for whom a particular housing option was unsuccessful.

Delivering on the Promised Intensity and Breadth of the Support Model

Another overarching theme is the challenge faced by the teams with delivering on the promised intensity and breadth of the support model, especially given the complexity of issues experienced by participants, regardless of whether their needs are rated initially as high or moderate. As mentioned in other parts of this report, various aspects of this challenge relate to the need for broad geographical coverage (e.g., in rural or large metropolitan catchment areas), after-hours support, as well as the frequency of support visits. The fidelity reports recognize that flexibility in providing after-hours visits may be limited by contractual issues and suggest ways of making community visits more efficient (e.g., using some office visits if preferable for participants and meeting participants in the community, rather than relying solely on home visits). Interestingly, while home visits were identified by some participants as reflecting a sense of their value and also as offering a sense of security that support would be there, overly frequent visits by different

workers asking the same questions were seen by some as intrusive and irritating. With respect to addressing breadth of support, the qualitative implementation evaluation reports identified strategies developed by teams to capture relevant resources (e.g., through network development with addictions agencies, contracting with psychiatrists and primary care physicians, etc.). These were identified as especially important for ICM teams, given the challenges faced in brokering resources to address the often complex needs of their participants.

Providing recovery-oriented support, as opposed to “fighting fires,” was identified as one particular challenge in meeting the promised breadth of support in the Housing First model. One lesson that was noted in the qualitative implementation reports was that teams have begun to address this issue, for example, by ensuring that employment specialists are in place (or moving towards establishing partnerships with relevant agencies), and by implementing illness management and recovery approaches into the teams’ regular practices. Towards this end, the fidelity reports emphasized the need to address apparent gaps in person-centred planning (the basis of motivational interviewing), and recommended further that community visits become more intentional (e.g., by employing a therapeutic recreation approach to visits), and thus oriented towards engagement and addressing quality of life issues (e.g., relationships, jobs).

As teams become more comfortable with the model, and the concerns about randomization diminish, another lesson is that teams can become more flexible, intentional and recovery-oriented in their interactions with participants. One particular issue that will remain challenging however, is the question of how the ICM teams, with their higher caseloads and lack of direct control over specialist resources, can address the needs of their participants with relatively complex needs. The fidelity reports and implementation evaluations suggest that part of the answer may lie in these teams becoming, in effect, more ACT-like in certain respects by moving towards shared caseloads, and by proactively capturing certain resources necessary (e.g., by contracting for psychiatric and addiction-related services, and by developing service agreements with philosophically congruent agencies offering recovery-oriented services) for meeting the varied needs of the participants. Although the fidelity report suggested moving towards shared caseloads, the ICM service team believes that this needs a fuller discussion. Caseload size and geography in Toronto make a shared caseload problematic unless there are issues of safety, making double visits a necessity.

Enhancing Staff Capacity

In general, the strong motivation of staff was acknowledged as a particular strength of the project. At the same time, the multidisciplinary nature of teams was an asset, presenting an opportunity for bringing diverse perspectives to addressing complex support issues, as well as an opportunity for cross-training and sharing of complementary expertise. As mentioned earlier, however, the challenges associated with providing intensive support to individuals with complex needs could translate into staff burnout and retention issues. The research process itself has contributed to such pressure, which will lessen once the demands of unpredictable recruitment rates lessen, and once learning curve issues are negotiated.

To address ongoing capacity challenges, the fidelity reports recommended that ICM team members could draw on the team-oriented approaches of ACT, and the self-care/mutual support benefits inherent in this approach. The national key informant report suggests that the second mixed method implementation evaluation should pay particular attention to related issues such as team leadership, cohesion and organizational culture, all of which contribute to staff’s collective ability to carry out the intervention in a way that is sustainable to the mental health of both staff and participants (Macnaughton & Curwood, 2011). Finally, the qualitative implementation reports suggest that teams are beginning to reframe initial anxiety into feelings of efficacy. One team, for instance, had initially viewed the early rehospitalization (three months after entry) of one participant as a failure. They subsequently realized that prior to the project, this individual had entered the hospital every two or three days, and that they had achieved a major breakthrough.

With respect to staff capacity, the findings suggest that as teams become more able to develop strategies and access necessary resources to meet the complex needs of its participants, issues such as burnout and retention will become

less of an issue. Our findings also suggest, however, that moving forward, it will be important to ascertain and influence key staff capacity issues such as team leadership, cohesion and organizational culture.

Focusing on Housing Procurement Strategies

The housing procurement strategy was acknowledged as a crucial, if tacit, aspect of the Housing First logic model, as well as an ongoing challenge to implementation. Rapid access to housing was deemed critical to early engagement, and seen as the fulfillment of a promise; early findings from the narrative interviews suggest that access to housing was also viewed by most participants as an envisioned stepping stone to life consolidation and recovery (Mental Health Commission of Canada, 2009). The fidelity reports, however, indicate that rapid access to housing remained an ongoing challenge for some teams. Successful access was seen as related not only to overcoming limited housing stock and other barriers (e.g., stigma and discrimination), but to devising effective strategies in relation to landlord relations and housing procurement. For example, one site mentioned the advantages of “active looking” based on participant preferences, as opposed to becoming overly reliant on building a stock of apartments to which participants’ choices would be limited. Access was also seen to be dependent on the choice of a nimble housing agency whose interests were primarily associated with the participant and clinical team. Both professional stakeholders and national key informants suggested that larger housing agencies with other client groups may be less willing to risk offering higher quality placements to project participants, given their interests in maintaining relations with landlords serving the wider base of clients. Both the fidelity reports and national key informant report emphasized that effective and timely housing procurement strategies required addressing both governance and teamwork issues, and recommended moving towards a model where housing team members were more fully embedded within, and accountable to, the clinical teams. Towards this end, the national key informant interviews suggested that housing and clinical teams could undertake joint training opportunities that move beyond their respective “communities of practice.” The fidelity reports also suggested that the clinical and housing teams collectively become more explicit about their approach to rehousing decisions, while guarding against a tendency towards limiting housing choices for rehoused participants. While we don’t want to unnecessarily limit choice, we have attempted to find a balance, and sometimes the service teams have had to limit some choices for a second and third rehousing based on how the first housing ended.

Finally, another important lesson is the importance to housing procurement of employing a nimble agency that can strategically develop relationships with landlords in a way that maximizes housing choice, and of the need for increased attention to teamwork and accountability issues surrounding how the housing and clinical teams work together.

Clarifying Accountability and Governance

A final theme relates to accountability structures and the governance model of the project at the site level. For instance, one site mentioned the problem of having unclear lines of communication and authority amongst the multiple agencies involved in the project. Another suggested that local committee structures, while democratic and often effective in the long run, were too unwieldy as decision-making bodies for solving immediate project needs. The national key informant report noted that democratic leadership styles, both at the site and national levels, have constituted a major strength, but suggested that the project would benefit going forward from a clearer accountability structure, for instance, acknowledging more explicitly the responsibility of the Site Coordinators, and being more explicit about who works for whom. In general, the training and technical assistance coordinated by the National Team was seen as a major asset, as was the opportunity for team members to travel to the Pathways program and see the model in action. A clearer accountability structure, however, would ensure that all the various strategies for assuring quality (training, technical assistance, fidelity measures, staff support, etc.) result in the faithful implementation of the Housing First approach in a way that is respectful of the needs and strengths of each site and its participants. Moving forward, accountability and governance will be important issues to address for the project as a whole.

REFERENCES

- Aubry, T., Cherner, R., Ecker, J., Jetté, J., & Philander, K. (June, 2011). *Implementation Evaluation Report for the Mental Health Commission of Canada's At Home/Chez Soi Project: Moncton Site*.
- Charmaz, K. (2006). *Constructing grounded theory*. London: Sage.
- Dudley, M., & Havens, M. (July, 2011). *Winnipeg Site Implementation Report*. Institute of Urban Studies, University of Winnipeg.
- Fleury, M.-J., Vallée, C., Hurtubise, R., Landry, A., & Grenier, G. (juillet, 2011). *Projet Chez Soi Montréal – Projet de recherche et de démonstration sur la santé mentale et l'itinérance: Rapport d'implantation – Phase de déploiement (1er année: 10-2009 à 12-2010)*.
- Goering, P.N., Streiner, D.L., Adair, C., Aubry, T., Barker, J., Distasio, J., Hwang, S.W., Komaroff, J., Latimer, E., Somers, J., & Zabkiewicz, D.M. (2011). The At Home/Chez Soi trial protocol: A pragmatic, multi-site, randomised, controlled trial of Housing First for homeless individuals with mental illness in five Canadian cities. *British Medical Journal Open* 1:e000323. doi: 10.1136/bmjopen-2011-000323
- Hawe, P., Shiell, A., & Riley, T. (2004). Complex interventions: How “out of control” can a randomised controlled trial be? *British Medical Journal*, 328, 1561-1563.
- Macnaughton, E., & Eckerle Curwood, S. (2011, September). *Implementation of the Mental Health Commission of Canada's At Home/Chez Soi project: Report on interviews with national and fidelity team key informants*.
- Macnaughton, E., Nelson, G., Piat, M., Eckerle Curwood, S., & Egalité, N. (2010, December). *Conception of the Mental Health Commission of Canada's At Home/Chez Soi Project*. Mental Health Commission of Canada.
- Mental Health Commission of Canada. (2011, April). *At Home/Chez Project early findings report*. Available at <http://www.mentalhealthcommission.ca/English/node/791?terminal=38>.
- Morse, J., & Field, P.A. (1995). Qualitative research methods for health professionals. In J. Morse & P.A. Field (1995). *Qualitative research methods for health professionals* (2nd Ed.). London: Sage Publications.
- Morris, J.M., & Niehaus, L. (2009). *Mixed method design: Principles and procedures*. Walnut Creek, CA: Left Coast Press.
- Mowbray, C.T., Holter, M.C., Teague, G.B., & Bybee, D. (2003). Fidelity criteria: Development, measurement, and validation. *American Journal of Evaluation*, 24, 315-340.
- Nelson, G., Goering, P., & Tsemberis, S. (in press). Housing for people with lived experience of mental health issues: Housing First as a strategy to improve quality of life. In C.J. Walker, K. Johnson, & E. Cunningham (Eds.), *Community psychology and the socio-economics of mental distress: International perspectives*. Basingstoke, UK: Palgrave MacMillan.
- Nelson, G., Macnaughton, E., Eckerle Curwood, S., Egalité, N., Piat, M., & Goering, P. (August, 2011). *Planning and proposal development for the Mental Health Commission of Canada's At Home/Chez Soi Project: Cross-site report*.
- Padgett, D.K (1998). *Qualitative methods in social work research*. London: Sage Publications.

Patton, M.Q. (2008). *Utilization-focused evaluation* (4th Ed.). Thousand Oaks, CA: Sage.

Patton, M.Q. (2011). *Developmental evaluation: Applying complexity concepts to enhance innovation and use*. New York: The Guilford Press.

Schmidt, D., & Patterson, M. (May, 2011). *The At Home/Chez Soi Project: Project Implementation at the Vancouver, BC Site*. Faculty of Health Sciences, Simon Fraser University.

Stergiopoulos, V., Hwang, S., O'Campo, P., & Jeyaratnam, J. (August, 2011). *At Home/Chez Soi Implementation Evaluation Toronto Site Report*. Centre for Inner City Health, St. Michael's Hospital.

Substance Abuse and Mental Health Services Administration (SAMHSA, 2008). *Permanent supportive housing: Evaluating your program*. DHHS Publication No. SMA-08-4509, Rockville, MD: Center for Mental Health Services, SAMHSA, U.S. Department of Health and Human Services.

Substance Abuse and Mental Health Services Administration (SAMHSA, 2010). *Permanent supportive housing: Evaluating your program*. DHHS Publication No. SMA-10-4344, Rockville, MD: Center for Mental Health Services, SAMHSA, U.S. Department of Health and Human Services.

Teague, G.B., Moser, L.L., & Monroe-DeVita, M. (2011). Established and emerging elements in the TMACT: Measuring fidelity to an evolving model. *Journal of the American Psychiatric Nursing Association*, 17(1), 34-36.

Tsemberis, S. (2011). Pathways Housing First program fidelity: The essential ingredients checklist (pp. 215-218). In *Housing First: The Pathways model to end homelessness for people with mental illness and addiction*. Center City, MN: Hazelden.

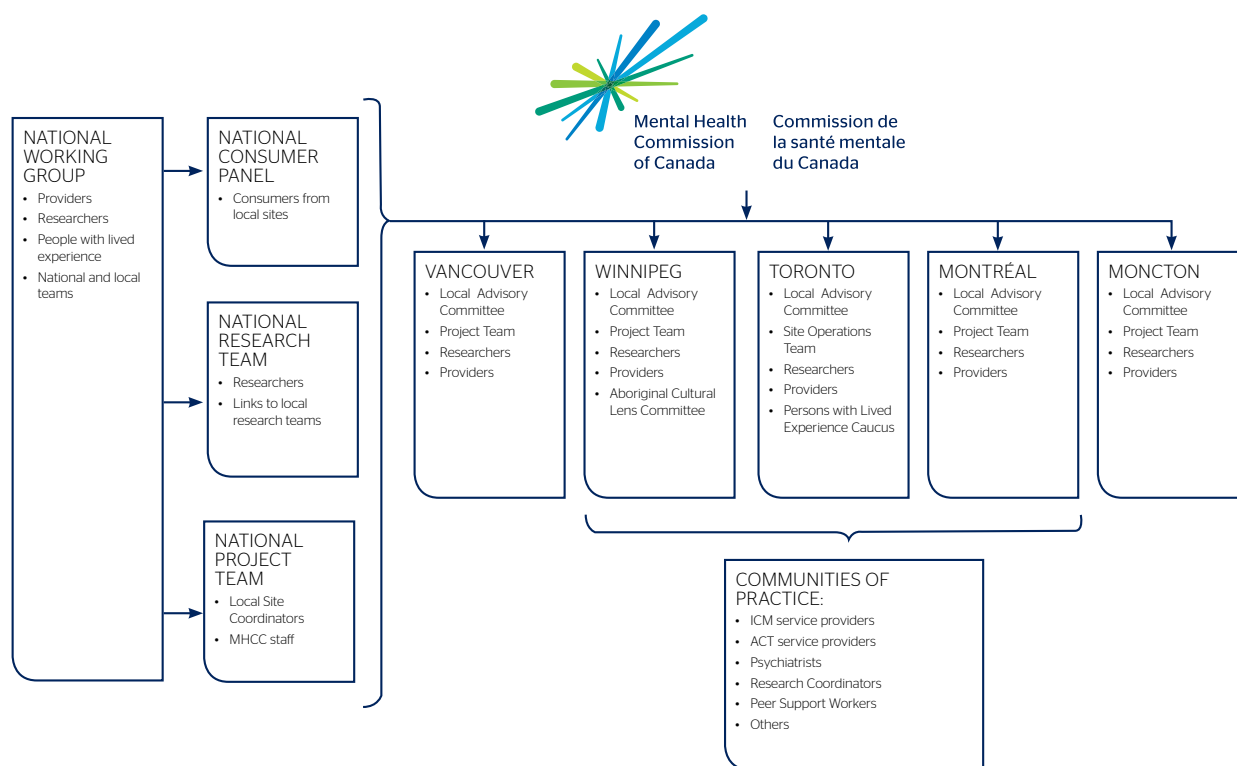
Tsemberis, S., & Asmussen, S. (1999). From streets to homes: The Pathways to Housing consumer preference supported housing model. *Alcoholism Treatment Quarterly*, 17(1/2), 113-131.

Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health*, 94(4), 651-656.

Williams, V.F., Banks, S.M., Robbins, P.C., Oakley, D., & Dean, J. (2001). *Final report: on the cross-site evaluation of the collaborative program to prevent homelessness*. Delmar, NY: PRA.

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.