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The At Home/ Chez Soi Project: Cross-Site Report on the Sustainability of Housing and Support Programs Implemented

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

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KEY MESSAGES

This report looks at the sustainability of the At Home/Chez Soi's (AHCS) housing and support teams in each of the project's five sites: Vancouver, Winnipeg, Toronto, Montreal and Moncton. The analysis is based on a cross-case analysis of themes emerging from case studies of each site. The themes relate to sustainability outcomes and processes, including factors and strategies that contributed to sustainability outcomes. This cross-site report complements a companion report that examined national-level sustainability strategies that also contributed to sustainability of the teams, as well as influencing federal homelessness policy (Macnaughton, Nelson, Goering, & Piat, 2016). This report examines the sustainability of the teams in relation to continued funding and fidelity of the teams' practice to the Housing First (HF) model. It also examines factors and strategies that contributed to sustainability at the site level, in terms of what worked well and what worked less well. There were some clear findings and lessons learned about the sustainability of AHCS HF programs. Findings and lessons learned are presented below in terms of what worked well and what worked less well.

What worked well?

- Nine of 12 AHCS programs continued.
- Overall, fidelity to the HF model among those programs was good.
- Research findings from AHCS were important for sustaining programs.
- Ongoing integrated knowledge translation and sustainability conversations with local, provincial and national stakeholders contributed to sustainability of the AHCS programs.
- Sustainability was most evident when it was aligned with local and provincial policy.
- Leadership and local partnerships for HF were important.
- There is a need for ongoing training and technical assistance to maintain fidelity to the HF model.
- Facts, values, strategy and persistence were important for achieving the sustainability of AHCS programs.

What worked less well?

- Loss of staff as the research demonstration phase of AHCS came to an end jeopardized sustainability.
- Sustaining rent supplements was challenging for some sites.
- Some provinces struggled with funding and inter-ministerial cooperation and had other policy priorities.
- There was opposition to program expansion from congregate, supportive housing providers.

EXECUTIVE SUMMARY

Background

This study examines the sustainability of the At Home/Chez Soi (AHCS) project housing and support teams in Vancouver, Winnipeg, Toronto, Montreal and Moncton. By sustainability, we are referring primarily to the continued existence of the teams and their ongoing fidelity to the Housing First (HF) model. As well, this research also looks at other important aspects of sustainability, such as maintaining partnerships with complementary agencies, the ongoing relationship and integration of HF programs with the surrounding systems of care and wider community, systems transformation, policy influence and the expansion of the HF model beyond the original sites.

The findings are based on cross-site themes that emerged from reports done at each of the project's five sites regarding sustainability outcomes and the factors and strategies that influenced these outcomes. The report is intended to complement a separate report that examined the sustainability of AHCS at the national level. The national sustainability report looks at the efforts of the project's National Leadership Team together with the Mental Health Commission of Canada (MHCC), to ensure the project's "safe landing" (i.e. a period of transition for each of the sites that would allow time for the site level sustainability strategies to occur) (Macnaughton, Nelson, Goering, & Piat, 2016). There is also a separate study that examined the sustainability of outcomes for participants.

Sustainability Outcomes

- Nine of the project's 12 teams were continued. Another team, which was a single-site program that was not originally planned for continuation, was gradually phased out.
- The teams that continued to practice did so with relatively high levels of fidelity to the HF model.
- There was some loss of funding for the nine continued teams. This resulted in compromises in terms of the amount of support provided and the ability of the housing team to procure spots for individuals who had lost their housing.
- For the three teams that were not successfully sustained, participants were transitioned to alternative supports and housing within "treatment as usual." However, because of

challenges within usual care (e.g. inflexible practices and eligibility criteria, no ability to rehouse in the event of eviction), stakeholders reported that a significant minority of these individuals lost access to support and lost their housing.

- While some teams maintained portable housing subsidies, participants from other teams were moved into subsidized social housing, resulting in challenges to the rehousing process (i.e. lack of access to units of equivalent quality and waiting lists).
- In Greater Vancouver and Winnipeg, there has been expansion of the HF approach.

Sustainability Processes and Strategies

The main facilitators of sustainability in relation to the continued funding of the teams were:

- Building strong relationships with decision-makers, both at the provincial and local level, which resulted in early “buy-in” to the project.
- Drawing on these relationships and employing effective knowledge exchange strategies which communicated the project’s findings, and thereby the value of the HF model to key decision-makers.
- Partnerships with key local leaders and champions who also supported the project’s continuation.
- Alignment of the HF model with existing policy and practices at the local and provincial level (e.g. anti-poverty strategies, provincial ACT initiatives).

The main barriers to the continued funding of the teams also related to similar factors, including:

- Lack of trust with key decision-makers (e.g. in Montreal, where the provincial government did not support AHCS).
- Difficulty obtaining the support of local leaders for sustainability (in some cases local leaders actively worked against the project).
- Incongruence of the the HF model with existing policy and practices (e.g. with congregate social housing, lack of portable housing subsidies).

The main facilitators of sustainability in relation to continued fidelity to the HF model include:

- Continued funding;
- Access to ongoing training and technical assistance; and
- Staff retention, especially of team leaders.

The main barriers to fidelity include:

- Lack of resources;
- Staff turnover and attendant lack of ability to train new staff;
- For some teams, lack of funding to maintain the housing specialist function, which affects housing choice and access;
- Lack of continued access to portable housing subsidies which hinders housing choice and the ability to rehouse; and
- Reduced resources hindering comprehensiveness of the available service array.

ACKNOWLEDGEMENTS

This cross-site report is based primarily 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:

1. *The At Home/Chez Soi Project: Sustainability of Housing and Support Programs Implemented at the Vancouver Site* (May 2015) by Michelle Patterson, Somers Research Group, Faculty of Health Sciences, Simon Fraser University.
2. *The At Home/Chez Soi Project: Sustainability of Housing and Support Programs Implemented at the Winnipeg Site* (March 2016) by Scott McCullough and Sarah Zell, The Institute of Urban Studies, University of Winnipeg.
3. *The At Home/Chez Soi Project: Sustainability of Housing Support Programs Implemented at the Toronto Site* (January 2016) by, Stephen Hwang, Pat O'Campo, Erin Plenert and Vicky Stergiopoulos, Centre for Inner City Health, St. Michael's Hospital.
4. *The At Home/Chez Soi Project: Sustainability of Housing and Support Programs Implemented at the Montreal Site* (March 2016) by Eric Latimer and Christian Méthot, McGill University.
5. *The At Home/Chez Soi Project: Sustainability of Housing Support Programs Implemented at the the Moncton Site* (February 2016) by Tim Aubry, Rebecca Cherner, John Ecker and Jennifer Rae, University of Ottawa.

Thanks also to each of the sites and to Aimee LeBlanc and Karla Thorpe of the Mental Health Commission of Canada for reviewing and providing feedback on an earlier draft of this report.

BACKGROUND ON AT HOME/CHEZ SOI

This report presents the overall findings from a study of the sustainability of the At Home/Chez Soi (AHCS) project. This pan-Canadian project was funded by the Mental Health Commission of Canada (MHCC), as was the sustainability research¹. AHSC was a five-year research demonstration project exploring ways to help the growing number of homeless people who have a mental illness. Building on existing evidence, AHCS strived to learn about what housing, service and system interventions can best help people across Canada who are living with mental health problems and illnesses and who have been homeless. The AHCS project was implemented in five cities across Canada: Moncton, Montréal, Toronto, Winnipeg and Vancouver.

This report focuses on the sustainability of the project after the demonstration period (January 2012 to September 2015). The AHCS project was a randomized controlled trial (RCT) of Housing First (HF) vs. Treatment as Usual (TAU) (Goering et al., 2011; Aubry, Nelson, & Tsemberis, 2015). Nested within each of these two experimental conditions were two groups of participants: those with high needs, who received support from Assertive Community Treatment (ACT) teams in the HF condition and those with moderate needs, who received support from Intensive Case Management (ICM) programs in the HF Condition. Additionally, sites had the option of developing a “third arm” or an intervention condition that was tailor-made to local conditions and needs, most sites developed a third arm.

The AHCS research found that the programs demonstrated a high level of fidelity to the HF model, both initially (Nelson et al., 2014) and after one year of operation (Macnaughton et al., 2015). Moreover, fidelity was significantly and directly associated with positive outcomes, including housing stability, quality of life and community functioning (Goering et al., 2016). After two years, HF participants showed significantly more positive outcomes than TAU participants on measures of housing stability, quality of life and community functioning, both in the ACT (Aubry et al., 2015; Aubry et al., 2016) and ICM (Stergiopoulos et al., 2015) programs.

¹The MHCC is a national not-for-profit organization that was established to focus national attention on mental health. While MHCC 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.

The sustainability research builds on previous research on the conception (Macnaughton, Nelson, & Goering, 2013), planning (Nelson et al., 2013; Nelson et al., 2015) and implementation (Macnaughton et al., 2015; Nelson et al., 2014) of AHCS. This research is particularly important because it provides data and important lessons about what happens after the demonstration period and how integrated knowledge translation strategies and contextual factors help or hinder dimensions of the sustainability of HF programs. Seldom are data of this nature systematically collected in such a project. This research provides evidence about how HF programs can be sustained with fidelity to the model and expanded to other settings.

LITERATURE REVIEW

Sustainability is a recent area of focus in implementation science that is conceptualized as both a component of evaluation (Savaya & Spiro, 2012) and a component of knowledge translation (KT) (Scheirer & Dearing, 2011; Stirman et al., 2012). Sustainability is a crucial component of community programs because without the capacity for sustainability, programs can damage trust with the community and waste resources (Schell et al., 2014). The most widespread definition of sustainability is that it is “...the continued use of program components and activities for the continued achievement of desirable program and population outcomes” (Scheirer & Dearing, 2011, p. 2060). Savaya and Spiro (2012) suggest that the key components of sustainability are continuation, institutionalization and duration.

Savaya and Spiro (2012) and Scheirer and Dearing (2011) both present reviews of the sustainability literature that highlight the importance of understanding the ecological context of sustainability. Sustainability of programs occurs in a complex environment where the program, funders, host organization and policy context are all important contextual factors that can influence sustainability. The ecological nature of sustainability necessitates consideration of how the broader health and housing systems or policy contexts may shift along with the program. A recent paper by Chambers, Glasgow, and Stange (2013) provides useful texture to the tension between fidelity and adaptation of programs during their sustainability phase. Chambers et al. (2013) suggest that “program drift” captures deviation from manualized protocols of programs. For these authors, “program drift” should be approached with caution as it may sometimes represent desirable changes in the program model as it moves from the research phase to the constraints of broader implementation. It is important to consider that drift may, at times, be a signal of innovation and that the program model will necessarily change as it seeks to find fit within practice settings.

In researching sustainability Savaya and Spiro (2012) and Scheirer and Dearing (2011) suggest that it is important to study outcomes that encompass both the key components of sustainability, such as continuation, institutionalization and duration, but also aspects of the ecological context and adaptation of programs. Savaya and Spiro (2012) suggest four broad categories of factors that influence sustainability, while Schiering and Dearing (2011) suggest three categories. Below in Table 1, we compare the influencing factors suggested from these two reviews and show how they are relevant to the AHCS project.

Table 1: Factors Influencing Sustainability

Savaya and Spiro (2012)	Schierier and Dearing (2011)	At Home/Chez Soi Research
Variables pertaining to the project	Characteristics of the intervention	The flexible and adaptable nature of Housing First to a shifting context Results/knowledge translation Factors that impact implementation also impact sustainability
Variables pertaining to the host organization	Factors in the organizational setting	Organizational support
Variables pertaining to the community	Factors in the community environment of each intervention site	Community support Local leadership that is supportive Efforts to integrate the pilot Housing First project into the regular system
Variables pertaining to the main funder		A favourable provincial policy and funding context

Schierer and Dearing (2011) suggest six outcome variables that reflect what sustainability is. Below in Table 2, we present these outcome variables suggested by the authors and the outcome variables relevant to the present study.

Table 2: Sustainability Outcomes

Schierer and Dearing's (2011) Sustainability Outcome Variables	At Home/Chez Soi Sustainability Outcome Variables
Whether benefits or outcomes for consumers, clients, or patients are continued (when the intervention provides services to individuals)	Ongoing funding for housing subsidies and clinical teams
Continuing the program activities or components of the original intervention	Staff retention and ongoing training Continued high levels of program fidelity
Maintaining community-level partnerships or coalitions developed during the funded program	Maintenance of local-level partnerships
Maintaining new organizational practices, procedures and policies that were started during program implementation	Institutionalization of Housing First Adaptations of the Housing First model
Sustaining attention to the issue or problem	Expansion/dissemination of Housing First (including changes in policy)
Program diffusion and replication in other sites	

The main elements of Schierer and Dearing's (2011) review that are relevant for the AHCS sustainability research are:

1. program continuation;
2. maintenance of community partnerships;
3. maintenance of organizational practices; and
4. program expansion.

RESEARCH QUESTIONS

There are two main research questions:

1. **Sustainability outcomes** – For the five AHCS sites, to what extent are the funding, fidelity, local-level partnerships, routinization, staff retention and expansion/ dissemination of HF programs sustained in the short-term and do these outcomes vary by site?
2. **Factors influencing sustainability outcomes** – What do stakeholders at the five AHCS sites view as the critical influences (i.e. At Home/Chez evidence about the effectiveness of HF, local capacity and contextual factors and planned and evolving sustainability strategies) on these different types of sustainability outcomes and do these influences vary by site?

METHODOLOGY

Mixed Methods Approach

A mixed methods approach was used to examine HF program sustainability (Macnaughton, Goering, & Nelson, 2012; Nelson, Macnaughton, & Goering, 2015). A quantitative measure of fidelity was used in conjunction with qualitative interviews regarding other sustainability outcomes and factors influencing sustainability.

Fidelity Evaluation

A fidelity assessment of continuing ACT and ICM HF programs was conducted using a staff-rated measure of fidelity (see Appendix 1). This 36-item measure assesses five domains: Housing Process and Structure, Separation of Housing and Services, Service Philosophy, Service Array and Program Structure (Gilmer, Stefancic, Sklar, & Tsemberis, 2013). Factor analysis of the scale has shown two orthogonal dimensions, the first encompassing the first three domains, while the second dimension encompasses the last two domains. All items were converted to a 4-point scale for consistency with previous HF fidelity research (see Appendix 2 for scoring instructions).

The survey was completed by a team of staff and consumers for a program in a group meeting. Staff were asked to complete the form individually in advance. At most sites, a group staff meeting was held in which the researcher/facilitator helped the group arrive at consensus ratings² for each item. Most sites had a researcher/facilitator who took field notes at the meeting. These data helped to shape questions for the qualitative focus groups, which followed the fidelity assessments. In some cases, it was not possible to conduct the fidelity assessments because the programs are no longer in operation.

² In Montreal and Winnipeg, the survey was sent to the team leads who completed it in conjunction with their staff and then returned it to the research team.

Qualitative Evaluation of Sustainability

Sampling and Sample

Key informant interviews: Individual key informant interviews were conducted with stakeholders at each site. Site researchers interviewed the former Site Coordinators, Principal Investigators (PIs) and team leads for ACT and ICM programs. They also asked Site Coordinators, PIs and team leads to suggest other people to interview (e.g. decision-makers, community partners). We also interviewed key informants at the national level regarding sustainability.

Focus groups: Sites conducted focus groups with staff that had experienced the transition from the demonstration phase to the sustainability phase. Sites also conducted focus groups or individual interviews with consumers who continue to receive the rent supplements and ACT or ICM. The sample sizes for key informant, staff and consumer interviews are noted in Table 3.

Table 3: Sample Sizes for Qualitative Research

Site	Key Informants	ACT/ICM Staff	Consumers	Total
Moncton	9	8	15	32
Montreal	9	-	-	9
Toronto	11	14 (3 FG)	9 (1 FG)	34
Winnipeg	11	9 (2 FG)	5 (1 FG)	25
Vancouver	10	4 (1 FG)	7 (indiv. interviews)	21
National	15	-	-	15
Total	65	35	36	136

Data Collection

The research employed document reviews and qualitative interviews to examine sustainability outcomes, influences and adaptations.

Document reviews: Site Coordinators, PIs and team leads were asked to provide documents pertaining to project site funding and budgets for relevant service-provider and housing teams, memoranda of agreements, service operations protocols and site operation team’s minutes of meetings, both during and after the demonstration phase (see Appendix 3).

Qualitative interviews: Qualitative interviews were used to examine sustainability outcomes, as well as the activities and strategies employed to achieve those outcomes, as well as other influencing factors. This included key informant interviews (see Appendix 4) and focus group interviews with staff (see Appendix 5) and consumers (Appendix 6). All interviews were audio-recorded and transcribed.

Data Analysis

The approach to data analysis at each of the sites involved thematic analysis (Braun & Clarke, 2006). 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 sustainability (Cherner, Ecker, Rae, & Aubry, 2016; McCullough & Zell, 2016; Méthot & Latimer, 2016; Patterson, 2015; Plenert, Hwang, O’Campo, & Stergiopoulos, 2016).

This cross-site report relied on the site reports as the source of data, rather than reviewing transcripts or other data from each site. For the cross-site analysis, members of the National Qualitative Research Team read the five site reports. Matrix displays were constructed using the sustainability outcomes, influencing factors and adaptations as one dimension and site as the other dimension.

These matrices were then populated with data from each site report (see Table 4 below). Researchers from the sites reviewed the cross-site report and their comments were incorporated into the final version of the report.

Table 4: Matrix Displays for Cross-site Analysis

Site	Program Fidelity, Drift and Adaptations	Sustainability Outcomes	Sustainability Influences
Moncton			
Montreal			
Toronto			
Winnipeg			
Vancouver			

FINDINGS

Sustainability Outcomes

Continued programs and funding after the demonstration phase

Nine of 13 programs continued from the demonstration phase into the sustainability phase (see Table 5). Since one of those programs was not intended to be sustained and was not a scattered-site HF program, nine of the 12 HF programs where sustainability was a goal were sustained. Prior to the end of the demonstration project, each site noted feelings of uncertainty expressed by participants and staff about sustainability of programs and the implications it would have on their jobs, housing and services.

Table 5: Program Continuation into the Sustainability Phase

Site	Programs during Demonstration Phase	Programs Continuing into the Sustainability Phase
Moncton	ACT	FACT
Montreal	ACT	
	ICM	ICM
	ICM	
Toronto	ACT	ACT
	ICM	ICM
	ICM Ethnoracial	ICM Ethnoracial
Winnipeg	ACT	ACT
	ICM Aboriginal	ICM Aboriginal
	ICM (Open)	ICM (Open)
Vancouver	ACT	ACT
	ACT Congregate	This program was not intended to be sustained
	ICM	

National context: From the outset of the project, sustainability of the HF teams beyond the formal end of the demonstration phase in March, 2013 had always been a concern. In January 2012, the National Leadership Team established a Sustainability Committee to consider strategies aimed at federal, provincial and local levels. As a result, the National Leadership Team, along with the MHCC's Government Relations team, began a series of meetings with federal and provincial representatives aimed at making decision-makers aware of the AHCS's positive interim results. In concert, sites established their own sustainability strategies headed by their own sustainability work groups. As well, all sites developed back-up transitional plans for ensuring that participants would continue to have access to housing and support should the demonstration teams not be sustained come March 2013.

The story of the national/provincial sustainability strategy and its outcomes has been discussed in detail in a companion report (Macnaughton, Nelson, Goering, & Piat, 2016). In brief, as a result of these efforts, in the fall of 2012, an agreement was reached between the federal government and the relevant provincial governments, with the exception of Quebec. In the agreement, the federal government would continue providing funding for the housing subsidies for a transitional year and each province would ensure that support remained in place for the participants. The federal government also offered funding for each site coordinator to remain in place for this extra year to coordinate activity during this transitional phase. In the lead up to March 2013 and in this transitional year, sites continued to negotiate for the long-term sustainability of the teams. These efforts and their outcomes are described below.

Moncton: Moncton's demonstration phase included one ACT program, which ended in March 2014. Administrative leaders from Regional Health Authorities (Vitalité and Horizon) assisted with the evolution of the ACT program over the next year into a Flexible Assertive Community Treatment (FACT) program. This FACT team changed the eligibility criteria for the program, whereby consumers did not need to be homeless or at risk of homelessness anymore. During the transition, the Department of Social Development and AHCS staff worked closely together to ensure participants from the project remained housed through rent supplements or by moving to subsidized social housing. Yet, the FACT program did not have the rent supplements to support AHCS participants if they lost their housing after the transition was over, resulting in consumers being added to waitlists for subsidized housing. In addition to physical relocation, program management and administration shifted from the Salvus Clinic to the New Brunswick Department of Health's Regional Health Authorities.

Montreal: Montreal’s demonstration phase included an ACT program affiliated with the Centre de Santé et de Services sociaux (CSSS) Jeanne-Mance, the Diogène ICM program and another ICM program also affiliated with this CSSS. Only the Diogène ICM program continued through the sustainability phase, which began in March 2013. As in other sites, the local team began discussions regarding sustainability and had been developing a plan around it for over a year. In February 2013, the CSSS Jeanne-Mance ICM and ACT teams transitioned participants to existing residential care facilities and intensive services and then the teams were dismantled. However, after transitioning to existing residential facilities and services and due to a variety of factors, dozens of participants subsequently lost their housing and/or access to support services. These factors included: large numbers of participants being transferred on such short notice; staff being inexperienced working with people with complex mental health and substance use issues; and lack of capacity to provide the same level of services to participants, such as helping participants find new housing if they lost their apartment.

The Diogène ICM team managed to acquire permanent funding from the Agence (regional agency that provides funding and training to health and social service providers in Montreal), continued to provide HF services to participants and received support from the Douglas Institute Housing team for over a year for housing, substance-use and mental health-related issues. The Office Municipal de l’Habitation de Montréal (OMHM) agreed to provide housing subsidies for all participants in scattered-site units until 2019. However, with the exception of the Diogène ICM team, support services operated considerably differently than during the AHCS demonstration period (i.e. services did not have to align with HF principles). International partnerships with France and other French-speaking countries implementing HF have increased the visibility and acceptance of the HF model in Quebec.

Toronto: Toronto’s demonstration phase included one ACT program, one ICM program and one ICM program that provided services for ethnoracial communities. The local team began discussions around sustainability and established a Sustainability Committee at least a year prior to the sustainability phase. Toronto’s demonstration phase ended in March 2013, and all three teams were sustained following the Ontario Minister of Health and Long-Term Care’s provision of \$4 million permanent, annual funding in February 2013. The funding provided was for housing and clinical supports, but also to ensure participants from the project were supported

in retaining their apartments. During the year of transition into sustainability, regular communication between the MHCC, Toronto's Site Coordinator, the AHCS research team and team leads helped to ensure sustained fidelity to HF model. The Toronto team described some of the fundamental aspects of their sustainability strategy, which included: identifying and promoting "a very specific 'ask'" (briefing paper with detailed budget to include services and rent subsidies to the Minister's office); targeting the provincial, rather than the city or federal governments because of the focus on mental health and housing; and ensuring that influential people (e.g. Members of Provincial Parliament and Ontario government ministries) were included in sustainability conversations, especially around funding.

Winnipeg: Winnipeg's demonstration phase included two ICM programs (NiApin, that served Aboriginal participants and Wi Che Win, which was open to both Aboriginal and non-Aboriginal participants) and one ACT program (Wiisocotatiwin). All of these continued through the sustainability phase that began in March 2013, albeit with reduced funding; there was also significant staff turnover, particularly in one team, related to the uncertainty over continued funding. The local team began transition discussions around sustainability and established a committee approximately one year prior to the sustainability phase. Similar to the Toronto team, the Winnipeg team's sustainability strategy included presenting a particular "ask" to the Provincial government's Minister of Health, which included details about the successes of the AHCS project, a funding proposal and justification for requesting \$5.1 million funding for two transition years. None of the AHCS participants lost their housing during the transition period between the demonstration and sustainability phases. Despite uncertainty, more permanent funding through various funding streams was eventually arranged through the Manitoba government, as well as through the federal Homelessness Partnering Strategy (HPS), eventually allowing for intake of new clients into programs created with new funds. However, fidelity to the HF model requires further evaluation since the original programs evolved since the demonstration phase of AHCS.

Vancouver: Vancouver’s demonstration phase included two ACT programs (RainCity ACT and Bosman Hotel’s congregate ACT), as well as one ICM program. Vancouver’s RainCity ACT team is the only program of the three to have continued through the sustainability phase, which began in March 2013. The Bosman was never intended to be sustained. As in the other sites, except Montréal, transition funding was provided for one year by the federal government to sustain housing for participants in all three programs. After the transition period, housing funding was taken over by provincial sources, namely BC Housing (for housing services) and Vancouver Coastal Health (VCH) (for support services).

With respect to discontinued programs, following the transition phase funding, most ICM participants maintained their housing but lost service supports that were provided during the demonstration phase team. About 20-30 participants were transferred to the sustained RainCity ACT program, while the rest were transferred to existing community mental health teams. Participants in the Bosman Hotel’s congregate ACT program transitioned to alternative congregate housing. BC Housing, VCH and Bosman staff worked together to find supports and housing for participants.

In contrast to the ICM and Bosman Hotel’s congregate ACT program, the RainCity ACT team was sustained due to many factors (discussed in greater detail later in this report) including: funding from RainCity Housing and VCH; training by the Motivation, Power & Achievement (MPA) Society, Coast Mental Health and Pathways to Housing; involvement and leadership of Peer Specialists and people with lived experience; and funding for research by VCH and the MHCC. Additionally, the RainCity ACT program retained its Housing Procurement Team responsible for acquiring scattered-site market rental units for participants, funded by BC Housing. While most AHCS HF participants in the RainCity ACT team retained their housing, some participants feared that market rental apartments would be unaffordable to them during the transition phase and chose to transition into BC Housing. Others who lost their housing through evictions during the transitional year and were not housed by March 31, 2014, were no longer able to acquire rent supplements. The Housing Team played a role in the development of HF programs to the Fraser Health and Vancouver Island Health Authorities.

Fidelity of those programs that continued after the demonstration phase

Across sites, program fidelity scores were consistently high, with average total scores ranging from 3.18 to 3.90 (out of possible score of 4, see Table 6). In the transition years, the clinical and housing services of programs that continued were sustained to varying degrees. Changes in funding sources generally resulted in the loss of housing teams and the transfer of this role to existing clinical teams resulting in lower Housing Process and Structure domain scores on fidelity evaluations for some sites. As well, across programs, no new rent subsidies were available, meaning that no new participants were entering the programs. Two of the Winnipeg programs and Moncton had average scores on the Housing Process and Structure domain that were 3 or lower. On the other hand, on the domain of Separation of Housing and Services, all of the programs scored high, with average scores on this domain ranging from 3.71 to 4.00. While there were changes in services, most notably at the Moncton site which transitioned from ACT to FACT, fidelity scores on the service dimensions, Service Philosophy, Service Array and Team Structure/Human Resources generally remained at a high level. The Moncton FACT team scored lower than 3 on the Team Structure/Human Resources, with reduced frequency of contact with clients. However, all of the other programs scored 3 or higher on the three service domains.

Moncton: In Moncton, the fidelity assessment revealed high levels of fidelity to the domains of Separation of Housing and Services, Service Philosophy and Service Array. Low levels of fidelity were reported by staff with regard to the domains of Housing Process and Structure and Team Structure and Human Resources. The low levels of fidelity observed were related to two substantive changes to the program model: a de-emphasis of housing in the delivery of the program, including a change in program admission criteria, and a shift to a FACT model from the ACT model. As mentioned, the program currently lacks access to housing resources, including portable rent supplements and prioritized access to social housing. Program participants who lose housing are referred to the Department of Social Development waiting list for subsidized housing in Moncton. The shift in clinical service provision from an ACT model to a FACT model was accompanied by new eligibility criteria that do not include being homeless or at risk of homelessness. The FACT team includes four members of the original ACT team and differs substantively in client to staff ratio which is now 1:20, rather than the 1:10 ratio it had during the demonstration period.

Montreal: Montreal's Diogène ICM scored perfectly on four of the five fidelity domains. The score on the Service Array domain of 3.51 was the lowest score.

Toronto: In Toronto the fidelity assessment revealed high levels of fidelity on all five domains. These results are consistent with an external fidelity assessment that was done during the sustainability phase. While the Toronto site received the majority of the funding requested from the province, there was not enough money to retain the housing team from the municipally-funded Housing Connections. A new housing coordinator role was established within one of the clinical teams. The large number of participants, low vacancy rates and difficulty maintaining positive relationships with landlords in Toronto have created challenges regarding the amount of time it takes to find new units and the choices available to participants. Additionally, the program has not received additional rent supplements so that no new participants are entering the program.

Winnipeg: In Winnipeg high levels of fidelity to the domains of Separation of Housing and Services, Service Philosophy and Team Structure/Human Resources were observed. Lower levels of fidelity were reported by staff of two programs with regard to the domain of Housing Process and Structure and by one of the ICM teams for Service Array. Low levels of fidelity were related to substantive changes to the program model: the precarity of funding to clinical service teams and the downloading of housing responsibilities onto clinical teams. At the end of the AHCS project, the province continued to fund the clinical service teams with a 30% reduction in their budget, the rationale being that the teams were serving fewer people. The teams initially faced short time windows on funding extensions which resulted in high staff turnover (Wi Che Win faced nearly 100% staff turnover) and exacerbated existing issues with staff burnout. A substantive effect of reduced clinical funding was the loss of cultural programming at NiApin for Aboriginal participants. The administration of rent supplements shifted from the Winnipeg Regional Health Authority (WRHA) to Manitoba Housing, while the previous job functions of finding units and maintaining relationships with landlords was downloaded onto already burdened clinical teams. This downloading of responsibility is particularly burdensome given Winnipeg's lower vacancy rate and has translated into reduced housing choice for participants and reliance on existing landlords.

Vancouver: Vancouver reported relatively high fidelity ratings for all five fidelity domains. However, scores were lower on the Housing Process and Structure domain relative to the other domains.

Fidelity scores for each item, domain and the total score are presented in Table 6 below for each of the programs that continued.

Table 6: Fidelity Domains, Items, and Scores by Program

(Note that all items were converted to a 1-4 scale, with 1 being the lowest fidelity rating and 4 the highest fidelity rating.)

Domains (potential range of scores)	Items	Scores								
		Van ACT	Win ACT	Win ICM – Wi Che Win	Win ICM – Ni Apin	Tor ACT	Tor ICM	Tor ICM Ethno -racial	Mont ICM Diogène	Monc ACT
Housing Process and Structure	Housing choice	4	1	4	4	3.5	3.5	4	4	4
	Neighborhood choice	4	4	4	4	4	4	4	4	4
	Furniture assistance	2	2	2	2	3	4	4	4	2
	Housing subsidies	3	4	4	3	4	4	3.5	4	2
	% income towards rent	4	3	1	4	4	4	4	4	1
	Time to move into housing	3	4	3	2	3	3	3	4	1
	% in different types of housing	3	3	2	4	3	3	4	4	1
	Average	3.29	3.00	2.86	3.29	3.50	3.64	3.79	4.00	2.14
Separation of Housing and Services	% sharing bedroom	4	4	4	4	4	4	4	4	4
	Requirements for gaining access to an apartment	4	4	4	4	4	4	4	4	4

	Requirements for staying in apartment	4	4	4	4	4	4	4	4	4
	Lease	4	4	4	4	2	4	4	4	4
	Provisions of lease agreement	4	4	4	4	4	4	4	4	4
	Rehousing when lose housing	4	4	4	4	4	4	4	4	2
	Services when lose housing	4	4	4	4	4	4	2	4	4
	Average	4.00	4.00	3.71	4.00	3.71	4.00	3.71	4.00	3.71
Service Philosophy	Determination of services	4	4	4	4	4	4	4	4	3
	Requirements for psychiatric treatment	4	4	2	2	4	4	4	4	4
	Requirements for substance use treatment	4	4	4	4	4	4	4	4	4
	Approach to substance use	4	4	4	4	4	4	4	4	4
	Activities to promote treatment adherence	2.5	4	4	4	4	4	4	4	4
	How treatment goals are set	2.4	4	4	4	4	4	4	3.6	4
	Life areas targeted for treatment	4	4	2.86	4	4	4	4	4	4
	Average	3.56	4	3.83	3.83	3.83	4	4	4.00	3.79



Service Array	Help to maintain housing	3	3	3	3	4	4	4	4	4
	Psychiatric services	4	4	2	4	4	4	4	4	3
	Substance use treatment	4	1.6	1.6	1.6	3.2	3.2	4	2.5	3.2
	Employment	4	4	3.2	4	2.4	3.2	3.2	4	4
	Education	4	4	4	4	3.2	3.2	3.2	4	4
	Volunteering	4	4	3.2	4	3.2	3.2	2.4	4	4
	Physical health	4	4	1.6	2.4	4	2.4	4	1.6	.8
	Peer specialist	4	4	NA	NA	4	NA	NA	NA	4
	Social integration	4	4	3.2	3.2	4	4	4	4	4
	Average	3.89	3.62	2.73	3.25	3.56	3.40	3.60	3.51	3.44
Team Structure / Human Resources	Targets chronically homeless with mental illness and addictions	3.33	4	4	2.67	4	3.33	4.0	4	4.0
	Client:staff ratio	4	3	4	4	4	4	4	4	3
	Face-to-face client/staff contacts per month	4	4	4	4	4	4	4	4	2
	Regular staff meetings	4	4	4	4	4	4	2	4	4
	Function of staff meetings	3.33	4	3.33	3.33	4	2.67	2	4	2.67
	Client input	2	2.67	1.33	2.67	2	1.33	2	4	1.33
	Average	3.44	3.61	3.44	3.45	3.67	3.22	3.00	4.00	2.83
	Total Average	3.52	3.65	3.31	3.57	3.65	3.65	3.62	3.90	3.18

Funding and budget outcomes

Funding and budget outcomes critically impacted sustainability across and within sites. Changes in funding sources and administration of funding impacted all of the sites, as did the uncertainty felt by stakeholders in each of the sites during the transition from implementation to sustainability phases. Funding outcomes varied across sites and to different degrees for each of the programs provided at each site. For some services, funding was discontinued altogether or provided at a reduced level. For teams that were continued beyond the transitional period, funding was provided by alternative and/or amalgamated sources.

In **Moncton**, the Department of Health through two Regional Health Authorities provided \$1 million collectively in transition funding to pay the salaries of the newly formed FACT service delivery team members (originally an ACT team during AHCS). The Department of Social Development funded housing services for former AHCS participants through rent supplements or transitions into subsidized social housing. However, due to limits in the funding, significant roles on the clinical support team were lost, as was some of the programming.

In **Montreal**, after negotiations both during the AHCS implementation and sustainability phases, the Diogène ICM acquired temporary funding and was eventually able to secure sustained funding for an unspecified time period, including rent supplements funded by the Office Municipal de l'Habitation de Montreal (OMHM). Participants from the dismantled teams still housed in their AHCS project apartment are receiving rent supplements from the OMHM until 2019. However, the other ICM and ACT team were both discontinued.

The **Toronto** site experienced positive funding outcomes, resulting in sustainability of all of its services during the AHCS implementation phase. Both ICM teams and the ACT team remained intact and were supported by \$4 million in permanent, annual funding for housing and clinical services, through the Local Health Integration Networks (LHINs) and the Ministry of Health. Unfortunately, the funding was not sufficient to: provide rent supplements for any new participants and support additional costs that were covered during the project (apartment insurance, moving support, last month's rent, damages).

In **Winnipeg**, following AHCS, the Department of Housing and Community Development of the Government of Manitoba (Manitoba Housing) became responsible for administering rent subsidies, which had been the responsibility of the WRHA during AHCS. Both ICM services and the one ACT team were sustained after a considerable period of uncertainty. Furthermore, the

Institute of Urban Studies, University of Winnipeg sustained funding for the Lived Experience Circle.

In **Vancouver**, federal transition funding was provided for one year for rent supplements for all participants and for leasing/staffing at the Bosman Hotel for the transition year. Following the transition funding, Vancouver Coastal Health funded the RainCity ACT team, a service which was sustained and modified staffing at the Bosman Hotel, a service which was discontinued. BC Housing funded housing services, but at a lower level than during AHCS. Funding was discontinued altogether for the ICM team and ICM participants were transitioned to existing community mental health services.

Staffing and service retention outcomes

Staff and service retention outcomes impacted short-term sustainability across sites and between clinical service teams within sites. The highest level of sustainability was the development of specialized teams and supports. The Toronto site, for example, was able to sustain its ICM team that focused on anti-racism and anti-oppression, in addition to developing more clinical support services for clients on ACT teams. However, Toronto site informants noted some staff turnover, which they believed could “threaten the knowledge base that the service teams have built up over the years of the project” (Toronto report, p. 22). Another level of sustainability involved retention of existing staff and service teams. In Vancouver, for example, one-year transitional funding at the federal level paid for rent supplements and salaries of the front desk staff at the Bosman Hotel, while BC Housing funded housing services and Vancouver Coastal Health funded members of the ACT team. A year following AHCS, Diogène in Montreal managed to retain 100% of its staff, from the demonstration phase.

Another level of sustainability involved modifications made to existing staffing and service teams, which occurred for many sites. Moncton informants reported losing key staff members, including their vocational coordinator, housing coordinator and physician who was the clinical lead for the ACT team. They created a new FACT service delivery team, allowing for larger caseloads, to replace the ACT team through the transition funding received from two regional health authorities (\$1 million in total). Original ACT team members had to reapply for their positions, resulting in only four team members, plus peer support staff, remaining on the team. While opinions of key informants from Moncton varied regarding extent of staff retention, one key informant stated:

“When we lost our housing coordinator, some relationships that were built with landlords, she had all the information. So the minute there was an issue, we would contact her, she would let us know who could deal with it. When this whole transition started and we lost that key person, we lost a lot of ... connections.”
(Moncton report, p. 28)

As mentioned, the Wi Che Win ICM team in Winnipeg experienced almost 100% staff turnover. The loss of cultural programming, due in large part to loss of staff, was also a significant change. Despite the large staff turnover, the team leads were retained, which was important to maintaining the integrity of the supports moving forward.

The lowest level of sustainability of staff involved no retention of existing staffing or service teams, requiring transition to existing community clinical services, unfortunately resulting in loss of some service delivery teams altogether. In some cases, for example, Vancouver and Moncton managed to transition participants from their discontinued services to existing community mental health teams. Montreal’s CSSS Jeanne-Mance ICM and ACT services were discontinued, resulting in various outcomes for staff, including being without employment, transferred to new Montreal ACT teams or to the existing mental health system and community organizations.

Housing outcomes: Housing outcomes were closely linked with funding and budget outcomes in impacting short-term sustainability across sites. The common theme related to housing outcomes across sites was housing and rent supplement retention.

Housing and rent supplement retention: Depending on funding outcomes, housing and rent supplement retention outcomes varied between sites and programs. Retention of rent supplements and housing for 216 out of 240 AHCS participants occurred at the Toronto site. For discontinued programs in Vancouver, most ICM participants retained their housing, while participants in the Bosman Hotel’s congregate ACT program transitioned to alternative congregate housing. For the sustained Vancouver program, RainCity ACT participants experienced a high level of housing retention as well. However, some participants chose to transition into BC Housing out of fear that they would no longer be able to afford market rental apartments following the AHCS program, and other participants that lost housing due to

evictions and were not housed by the end of the transitional year could no longer acquire rent supplements to acquire new housing.

While some consumers who received housing during the implementation phase were able to retain their housing, a transition resulted for some participants in Winnipeg and Moncton, who moved into either Manitoba or Moncton social housing units or other subsidized, lower cost housing. This outcome resulted from portable rent supplements no longer being available and transitioning participants into subsidized housing was one affordable option. The Winnipeg site reported that a small group of participants maintained tenancies in high-subsidy housing beyond the transition year. However, some participants who could not access public housing or affordable private units moved into single room occupancy (SRO) hotels or rooming houses. Similarly, during the transition of housing services to the Department of Social Development in Moncton, some participants lost their housing and remained homeless while they were put on a wait list for social housing.

Expansion outcomes: HF programs did not expand for Moncton, Toronto or Montreal, but did grow in Winnipeg and Vancouver. In Moncton, limited funding resulting in lack of rent supplements and lack of strategies around advocating for program sustainability precluded many aspects of HF program expansion and key informants agreed that HF had not adopted anywhere else in the province. However, with support from the Salvus Clinic and United Way, the peer supportive housing program was not only maintained, but also expanded to include two apartment units. In Montreal, enduring opposition by the Quebec government largely limited the ability of expansion for HF programs in the province. Some stakeholders said that while the provincial government eventually showed interest in HF due to the proven efficacy of the model and the AHCS project, any expansion of the model would be done under a name unassociated with the HF model or the AHCS program. In Toronto, the lack of expansion was largely due to the fact that "the teams' clinical capacity currently far exceeds the number of rent subsidies to which the teams were given access. This has meant that any new referrals would only receive clinical supports from the teams, with no rent supplements to enable access to independent housing" (Toronto report, p. 28).

HF programs in Winnipeg have expanded with funding from the Manitoba Government and HPS. Housing Plus, a centralized housing procurement agency in Winnipeg, provides housing-with-supports to the three established AHCS programs, as well as for Resource Assistance for

Youth, West Central Woman's Resource Centre (These Four Walls), Urban Eagle Transition Centre (Fresh Start) and Ma Mawi Wi Chi Itata Centre (Beaver Medicine Bundle Youth Program). HF principles have also been accepted within the Plan to End Homelessness in Winnipeg and by the End Homelessness organization. Given that AHCS was envisioned in Winnipeg as having an objective of capacity building for a community that previously had no experience with HF, the incorporation of HF principles represents an acceptance of the approach into a broad strategy to alleviate homelessness and poverty.

Due to sustained rent supplements for AHCS participants in Vancouver, some stakeholders believed HF was being embraced by BC Housing. There was also some expansion of HF to include Fraser Health Authority and Vancouver Island Health Authority. Though HF in both of these areas was being implemented at the time of the AHCS project, AHCS played a role in the approaches' expansion in Fraser and may have contributed to a climate of expansion on Vancouver Island. However, some stakeholders believed that aside from providing rent supplements, which were insufficient in light of Vancouver's rental market, real expansion and integration of HF was not happening in the existing service system.

Factors Influencing Sustainability Outcomes

Stakeholders viewed the following factors as critically influential on sustainability outcomes:

1. The dissemination of research evidence
2. Peer support, partnerships
3. Ongoing training and technical assistance
4. Community contextual factors, funding and policy contextual factors
5. Factors related to leadership
6. HF system integration factors

1. The dissemination of research evidence

The dissemination of research evidence impacted sustainability across sites. Some stakeholders believed that the research findings positively impacted the sustainability of AHCS, while others identified challenges associated with dissemination strategies, such as tension about where the leadership would come from (national vs. local) and tension about what should be sustained. Dissemination strategies used both internally (between AHCS project teams) and externally (between AHCS project and stakeholders outside of the project) were evident amongst the sites.

Positive comments made about research dissemination internal to the project included receiving informal updates about the research in the form of reports and presentations. This research dissemination was helpful in sustainability planning. Challenges associated with AHCS research dissemination within the project mentioned by key informants included delays between the availability of research findings and conversations about sustainability and a lack of collaboration between research and practice teams.

The most common external dissemination strategy was negotiating incongruencies between the HF philosophy and the values of AHCS and with the more traditional mental health system that values more treatment-first, congregate housing models. In addition to integration of learnings about landlord engagement and the significance of consultation with Aboriginal communities in

initiating and sustaining programs, the Winnipeg report noted a respondent that "spoke of a broader recognition of harm reduction in the health community as coming out of the At Home/ Chez Soi project" (p. 38).

Additionally, key informants and program staff at the Moncton site noted that discrepancies existed between information being disseminated by the provincial government to the media and what the government's actual plans were with respect to sustainability of the project. A few noteworthy comments regarding positive external dissemination outcomes included the Montreal report stating that dissemination of AHCS data has contributed toward a HF approach used internationally, specifically in France and Belgium. In Winnipeg, AHCS research dissemination strategies were targeted to policy makers and the broader public, including people with lived experience of homelessness, using an approach that featured the involvement of project participants. Additionally, a key informant in Winnipeg said:

"There's been a huge impact. I think all of those sector groups have recognized that At Home/Chez Soi demonstrated success with the Housing First approach. And that overall it had very good results for the participants who were stably housed; for cost savings for the bigger system; and for better matching services to the needs of those folks. So I think the research definitely demonstrated that..."
(Winnipeg report, p. 36)

Overall, the research provided the numbers to support the model and demonstrate that HF could be delivered in a locally adapted and culturally sensitive way.

2. Peer support

Peer support profoundly impacted sustainability across Vancouver, Moncton, Montreal and Winnipeg. All four sites noted the important roles played by peer support workers in improving and sustaining not only HF programs, but within the formal mental health systems of their respective provinces. The Vancouver ACT team's Peer Specialists, as well as members of the Speaker's Bureau, became actively involved in attending conferences on housing and mental illness. In Moncton, Peer Specialists remained involved as paid staff within the new FACT team, and their peer supportive housing program was not only sustained, but also expanded through support from the Salvus Clinic and United Way. One key informant in Moncton stated that:

“We’re doing it in all aspects of our program service delivery now to be honest with you. We’re listening to people with lived experiences in a way that we never have before... I think this health authority is pioneering, making sure that we’re listening to clients’ voices and what they need, rather than telling them what they need. Not a medical model, and it is definitely a collaborative one. So I think that the At Home/ Chez Soi project certainly opened the doors for us to be able to do that.”
(Moncton report, p. 32)

As mentioned earlier, in Montreal, peer support workers became actively involved in research and knowledge exchange activities in Europe and some of the peer support workers from the AHCS project were hired permanently in the mental health system to expand roles for peer support workers. In Winnipeg, the recognition of the contributions of persons with lived experience and their full inclusion — particularly through paid employment in the service sector — has yet to be realized. The Lived Experience Committee (LEC) reports that they are often expected to contribute their time and knowledge in a voluntary or token capacity and while progress is being made, this remains disheartening for them

Partnerships

Across sites, key informants emphasized the importance of initiating and sustaining strong, strategic partnerships at local, provincial and federal levels; between service teams (i.e. ACT, ICM); across social service sectors (i.e. mental health, housing, employment, income assistance, etc.); and between the government, not-for-profit and non-governmental organizations. The importance of forming partnerships with individuals and groups that value HF principles and philosophy, (i.e. around capacity-building, harm-reduction, consumer choice), remained consistent across sites. However, each of the sites emphasized specific, yet different characteristics of partnerships that were fundamental to creating strong relationships that sustained the programs. For example, Winnipeg emphasized the importance of creating culturally respectful partnerships between local Aboriginal and non-Aboriginal service agencies, educational institutions and governments, while in Montreal, international relationships with French-speaking countries (i.e. France, Belgium) implementing HF were emphasized. Key

stakeholders from two sites (Winnipeg and Toronto) emphasized the impact of relationship history in sustainability. A key informant from the Toronto site said that “a history of trust and support between all stakeholders” (p. 5) was important and the Winnipeg site emphasized the city’s long history of social activism, particularly around Indigenous and inner city issues. One key informant stated the following:

“I think number one, Winnipeg is small; as big as it is, it’s small. I think its relationships. I’ve been around over 30 years doing stuff in the inner-city... All three of us, we continued working together, we stayed united, we didn’t let people piss us off, you know? And I think [that’s] because we were innovative and creative thinkers and we wouldn’t say no, we wouldn’t take no, and we kept on pushing.”
(Winnipeg report, p. 47)

There were three common levels of partnerships reported across sites as being critical to short-term sustainability, including: national-level partnerships, provincial-level partnerships and local-level partnerships. These levels are not independent of one another; they overlap and are interrelated in many regards. On a national level, sustaining relationships with influential federal decision makers as well as sustaining fundamental relationships with the MHCC and HPS were deemed essential to sustainability outcomes for all of the sites.

Provincial-level partnerships: Formation of strong partnerships with provincial decision makers was emphasized as a key influencer of sustained housing and clinical support services. Unfortunately, the opposite was true as well, whereby weakness in the strength of relationships contributed to discontinuity. Moncton’s intersectoral collaborations with the Department of Social Development, the Department of Health and the Regional Health Authorities created partnerships within the AHCS demonstration project. Partnership with the Ministry of Social Development was seen as critical in Vancouver. In Manitoba, a variety of provincial-level partnerships were seen as important, including with: Manitoba Housing, Manitoba Health, the Cross-Departmental Coordination Initiative (CDCI) and the Winnipeg Poverty Reduction Council.

Local-level partnerships:

- Relationships with **landlords** and/or **building managers** impacted sustainability across every site.

- Additionally, partnerships with **governmental organizations** were fundamental to sustainability. In Moncton, key informants discussed the importance of the Regional Health Authorities (Vitalité and Horizon), as well as communication between the Department of Health and the Greater Moncton Homelessness Steering Committee. Montreal’s partnership with the Office Municipal de l’Habitation de Montréal (OMHM) was imperative to sustainability and Vancouver’s partnership with Vancouver Coastal Health are additional examples of important partnerships. In Winnipeg, some partnerships were with the Community Mental Health Department of the WRHA and with Employment and Income Assistance.
- **Community organizations and academic institutions** were fundamental influences in sustainability across sites. In Moncton, consumers were able to apply for ongoing housing through community agencies, such as the YMCA and the John Howard Society. The food bank and various educational programs were partners of Moncton AHCS as well. Community organizations supportive of HF were fundamental partners, such as the Salvus Clinic, which offered health care services to consumers during the sustainability phase. In addition, the United Way in Moncton provided two peer support housing units to support consumers who had experienced difficulty achieving housing stability within the AHCS program. Montreal’s partnership with the Projet Réaffiliation en itinérance et santé mentale (PRISM), a collaboration between the Old Brewery Mission and the Centre hospitalier de l’Université de Montréal (CHUM), of which helped to recruit and refer participants to Diogène. Partnerships with the Institut universitaire en santé mentale de Montréal (IUSMM), the Douglas Institute and two women’s shelters (Le Chaînon and La Maison Marguerite) were mentioned as well. Winnipeg partnerships included the University of Manitoba and the Institute of Urban Studies at the University of Winnipeg.
- **Clinical service teams and local hospitals** were essential to sustainability. In Moncton, the Mobile Crisis team, behavioural therapy services, psychological services, and psychiatric services were essential and in Montreal, psychiatric services were emphasized as well. Central to sustainability in Toronto was the partnership between the three mental health service agencies and their development of a shared Memorandum of Understanding. In Winnipeg, the ACT team is hosted by the Mount Carmel Clinic.

3. Ongoing training and technical assistance

All sites referred to ongoing training and technical assistance as a critical influence on sustainability, although this was stated more explicitly in some sites. Toronto key informants referenced national and regional level funding provided for training and technical assistance, which helped support and sustain communities using HF and communities of practice. Both the Toronto and Moncton sites emphasized the importance of providing ongoing training and technical assistance, especially with staff turnover during the sustainability phase of the project in order to orient staff to the HF model. One Toronto key informant said:

“One of the things that we’ve made sure we’re going to have done is the new staff coming in [...] they’re going to have to go through getting the Housing First training to make sure they’re up to speed and even offer it back to some of the original staff because it’s been awhile and we want to make sure that everybody is in compliance with what it is we’re trying to do with the program.”

(Toronto report, p. 22)

Moncton informants reported that some of the staff were trained with a recovery orientation in motivational interviewing, first aid and suicide prevention, not necessarily pertaining to a HF approach, but from a general mental health perspective. Due to lack of financial resources during the sustainability phase, in contrast to the implementation phase, limited training was provided for many staff members and managers and a noteworthy lack of training in the new FACT model, which Moncton key informants attributed to a decrease in the quality of service delivery.

Key informants identified that difficulty acquiring adequate training was a challenge to sustainability, in the sense of ongoing fidelity of HF for Winnipeg’s ICM teams and HF teams in Montreal. Stakeholders in Montreal viewed barriers to acquiring adequate training to be the Ministère de la Santé et des Services sociaux’s (MSSS) refusal to accept HF training offered by the MHCC and Pathways to Housing, and the lack of readily available French training materials (though the *Canadian Housing First Toolkit* is available in French). Similar to Montreal and Winnipeg, Vancouver stakeholders viewed training and technical assistance as important influences of sustainability. However, unlike these sites, the Vancouver RainCity ACT team managed to acquire direct technical assistance from Pathways to Housing. Furthermore, RainCity, MPA and Pathways to Housing collaboratively developed a training curriculum for new

staff. Additionally, part of ACT team development in Fraser Health Authority included partaking of ongoing training and technical assistance.

4. Community contextual factors

Across sites, the housing landscape and partnerships were common factors influencing sustainability within the community context. The **housing landscapes** in Moncton, Toronto, Vancouver and Winnipeg created challenges to HF sustainability. Key informants frequently referenced issues regarding low vacancy rates and lack of affordable and high quality housing, as well as high demand and long waitlists for support and housing services. Limited choice and opportunity for consumers resulted from these issues. **Partnerships** were an essential influence on sustainability. Strong partnerships with community organizations, landlords and local government organizations, as well as access to community resources and services were essential for all sites and each service that was sustained. However, established relationships often needed to be rebuilt or reestablished depending on levels of staff turnover and philosophies adopted by these partners, because they impacted the strength of the partnerships and hence, the ability to mobilize supports and resources. For example, the Vancouver report states that:

“... the local health authority (VCH) underwent significant reorganization at the levels of both programming and senior leadership, therefore, many of the senior staff at the end of VAHS [Vancouver At Home Study] were new to their positions and did not have knowledge of VAHS or the ability to advocate for its sustainability (let alone expansion) within their organization. However, VCH did provide continued funding for the VAHS support services as well as 1-year of funding for continued follow-up research.”
(Vancouver report, p. 29)

Another example is Montreal, where key informants stated that:

“... many of the key senior managers in the formal mental health system, who were quite supportive of the AHCS project and of HF, have now retired, moved to other unrelated functions or have been dismissed. This makes it harder and more complex for stakeholders who are still operating in the formal mental health system to promote HF or practices derived from it...”
(Montreal report, p. 9)

Funding and policy contextual factors

The funding and policy contexts varied across sites, however two cross-site themes influenced program sustainability, including **alignment between HF and existing policies and practices** and the **provincial economy**.

Toronto stakeholders emphasized the importance of leveraging “funding and policy windows,” in particular the province’s emerging Anti-Poverty Strategy, which was the vehicle through which funding for the project’s continuation was achieved. Toronto, Vancouver and other sites created task forces and employed lobbying strategies which exploited policy windows. In British Columbia, the development of ACT teams by regional health authorities (in Vancouver, the Vancouver Coastal Health Authority) provided the policy opening which RainCity used to gain ongoing funding for its HF ACT team. Other health authorities in BC, including Fraser Health and Vancouver Island Health Authority, have also used this policy window to develop HF ACT teams. In Winnipeg, the provincial government, along with the new HPS mandate of funding HF programs supported sustainability. Key informants in different sites also stressed the importance of acquiring early “buy-in” from the provincial government to influence sustainability.

On the other hand, a lack of alignment between the HF model and existing policy and practice also represented a barrier to sustainability. Toronto stakeholders emphasized resistance from supportive housing service providers where “there appeared to be a level of fear around losing their base funding as the funding and policy climates began to shift toward more Housing First approaches...” (Toronto report, p. 17). Similarly, pre-existing policy initiatives in Vancouver supporting service provider preferences for traditional approaches of congregate housing created resistance. At the same time, in Montreal, the Continuum of Care model posed a barrier to shifting toward a HF approach. Regardless of the HPS’s new focus on HF, the Quebec government did not embrace the federal policy shift regarding HF and continued its emphasis on social housing. In Moncton, during the ACT team shift to a FACT model, the disconnect between housing and support policies and services of the Department of Health and the Department of Social Development created “a critical barrier to the sustainability of the Housing First model” (Moncton report, p. 35) and no mechanism was made available to provide rent supplements for consumers. While there has been some movement at the policy level towards the more widespread use of rent supplements (e.g. BC Housing), for the most part the policies adopted by housing ministries and authorities have not been conducive to the use of the portable rent supplements that are essential to the HF model.

Across sites, competition for resources, which could be exacerbated by weak provincial economy was described as influencing sustainability. Availability and distribution of funding largely depended on the state of regional, provincial and federal economies. Stakeholders in Toronto and Winnipeg described difficulties acquiring funding for HF at regional and provincial levels mainly due to competing interests, values and programs all vying for the same funds and resources. For example, the Toronto report describes “several lobbying groups competing for limited resources,” a response echoed in Winnipeg. Also, despite Montreal’s social housing system, stakeholders still claimed that “social housing and already existing services were in dire need of financial resources” (Montreal report, p. 1). However, during the sustainability phase, both Winnipeg, having had a serious and costly flood in 2011, and Moncton experienced unique challenges, whereby significant provincial fiscal constraints existed as a result of a large deficit. The Moncton report stated that:

“... key informants and program staff acknowledged that the economic realities of the province and scarcity of funding was an important factor affecting program sustainability. The province was described as “*very poor*” and “*essentially bankrupt*,” with the demand for subsidized housing exceeding funding availability. Key informants considered the cost of the services delivered through the AHCS project too expensive to be maintained by the province.”

(Moncton report, p. 36)

5. Leadership factors

Across sites, leadership fundamentally influenced sustainability – both strong leadership *for* HF and AHCS, or lack thereof, and strong leadership *against* HF and AHCS were discussed. Specific individuals, project teams, project committees, community groups and government affiliates were mentioned as leaders at varying levels – on service teams, local levels, provincial levels and federal levels. Additionally, HF champions that played dual roles both within the AHCS project and various governmental roles were deemed essential to sustainability.

Informants from Moncton and Vancouver sites emphasized the importance of strong leadership on all levels. For example, the AHCS Project Lead, Site Coordinator, Team Manager, Local Advisory Committee and Regional Directors for the Department of Social Development were

seen as essential in Moncton during the demonstration and transition phases. However, key informants emphasized how detrimental the loss of some of these leaders was during and after the sustainability phase and indicated that increased leadership to ensure the sustainability of the program after the end of AHCS would have been helpful. In Vancouver, the lack of influential leadership was noted as well during the sustainability phase for additional reasons. For example, with significant reorganization of the local health authority in Vancouver, many newer staff members were not knowledgeable or experienced enough with AHCS to advocate effectively for sustainability. Furthermore, despite funding provided by the BC Ministry of Health for various housing and support initiatives, many stakeholders perceived a lack of leadership on their behalf. Despite these perceived drawbacks in leadership, while some stakeholders reported a lack of project leadership by the MHCC, most stakeholders reported that senior leadership in the MHCC led project sustainability in Vancouver. Furthermore, strong leadership by Peer Specialists and persons with lived experience in Vancouver's RainCity ACT team had largely impacted not only the sustainability of the team, but also expansion of the roles of peer work in the mental health and addictions system.

In Montreal, Diogène's ICM team leadership in ensuring sustained negotiations with Montreal's health authority largely led to sustainability of this program during the sustainability phase. However, many political leaders and groups in Quebec, including one particular community organization with distinct political influence "systematically advocated against AHCS and HF over the media, Internet, in public events, in research events and in the bulletins and reports that they publish on a regular basis" (Montreal report, p. 15). Additionally, leadership in the Agence, the regional agency that provides funding and training to health and social service providers in Montreal, strongly resisted HF and AHCS during all phases of the project and stakeholders did not identify any political forces seemingly strong enough to oppose this resistance. In fact, the Montreal report states that: "Lack of leadership in facilitating implementation of the [HF] model will result in homeless people remaining in the street for a very long time" (p. 19).

In contrast to Montreal, the Toronto and Winnipeg reports discussed experiences of strong HF advocacy by certain political/program leaders, who played dual roles to assist in program sustainability, as well as additional strategies used which related to leadership. The Local Site Coordinator in Toronto was mentioned multiple times by key informants as a particularly valuable advocate for AHCS sustainability. Much of her advocacy skills were attributed to "her past experience working in the Ministry, her ability to leverage the relationships that she had with government officials and her understanding of the importance of involving key individuals

early in the sustainability conversation” (Toronto report, p. 20). Similar strategies were employed in Winnipeg, whereby some senior-level leaders, at both the local and provincial levels, stopped their involvement in the project and returned to their governmental roles, where they successfully advocated for project sustainability from within the system. Furthermore, in addition to strong and sustained leadership from local Indigenous communities in Winnipeg, all three team leads remained on the teams (NiApin ICM, Wi Che Win ICM and ACT) during the transition phase. Their sustained leadership in the face of funding cuts and high staff turnover helped ensure program sustainability and continuity in service delivery.

6. HF system integration factors

System integration refers to the degree to which HF values and philosophy have been adopted by the existing, more traditional housing and health care systems. The **degree of HF system integration and resistance experienced** during these complex processes varied across sites and influenced not only sustainability outcomes, but also the **other factors** that influenced these outcomes (i.e. staffing and service delivery factors; community contextual factors; funding and policy contextual factors; and factors related to leadership). Every site emphasized certain factors associated with successfully integrating HF into the broader, more traditional service delivery systems. As one key informant in Vancouver stated: “HF blows up the silos and the jurisdictional authorities. I think that’s what’s both fascinating and exciting, as well as challenging, in terms of truly moving forward with a Housing First model” (Vancouver report, p. 27).

- **Degree of HF system integration and resistance experienced:** The Toronto site expressed some system integration noting success in influencing mental health, addiction and housing system practices, including:

“... the inclusion of an ICM team focused on serving racialized communities, which continues to work with clients from an anti-racist and anti-oppression (AR/AO) perspective; the incorporation of more clinical support to clients on ACT teams; reducing stigma in the areas of mental health and homelessness; and, at both a national and regional level, both MHCC and HPS have funded training and technical assistance to communities embracing HF and emerging communities of practice, part of AH/CS’s knowledge translation strategy.” (Toronto report, p. 6)

Despite these achievements and in addition to acquiring permanent funding for HF programs, the Toronto site report states that the: "... Housing First philosophy has not yet been widely adopted and will remain fragile until we move from a conversation about sustainability to a conversation about system transformation and accountability..." (Toronto report, p. 6). Similar to Toronto, the Vancouver site reported some system integration, as well as describing this integration as "fragile" (Vancouver report, p. 25). Despite adoption of a HF philosophy and perhaps a paradigm shift on a municipal level by some non-profit organizations and clinicians and incorporation of AHCS learnings as part of the downtown east side's Area Plan and Mayor's Task Force on Mental Health and Addictions, most key informants described system integration occurring in "small pockets" (Vancouver report, p. 25). They also agreed that HF had not been integrated systemically at local or provincial levels.

While sustainability outcomes differed substantially between Moncton, Vancouver and Toronto, the degree of HF system integration was described similarly, whereby some system integration seemed to occur. The HF model seemed to be supported within the community, by BC Housing and the Fraser Health Authority and within small organizations providing social services. Most system integration was with respect to regional and provincial adoption of community mental health teams, as well as peer support roles within mental health service delivery systems. However, the Moncton report states that: "the mental health service system has not changed in terms of offering housing services and has not shifted to a Housing First model" (Moncton report, p. 4) and "the Housing First model as a whole was not adopted within New Brunswick" (Moncton report, p. 7). As mentioned, in Winnipeg, the implementation was envisioned in terms of community capacity building. Key informants believed that this enabled room for system integration.

Despite significant resistance experienced from all levels of government and traditional service delivery systems at the Montreal site, some system integration became apparent just over two years following the AHCS project. Discussions had shifted between stakeholders to recognize HF's potential to change systemic responses to homelessness in Quebec. In addition to Diogène's steadfast commitment to the HF model, many organizations have begun to adopt HF principles and partnerships with other French-speaking countries such as France and Belgium, that are also

implementing HF, had indirectly led to a growing recognition and acceptability of the model in Quebec (p. 5).

- **Common integration factors:** Integrating a HF model into traditional contexts, whereby biomedical health approaches and congregate housing models dominate service delivery systems in Toronto, Vancouver, Moncton and Winnipeg, as well as the continuum of care model predominant in Quebec, proved challenging. Across sites, common factors were described as influential to system integration and hence, program sustainability. The need to shift conversations, philosophies and overall paradigms around housing people with complex mental health needs was emphasized. The necessity of rent supplements/subsidies and flexibility in subsidy provision to effectively implement a HF model was reported across sites. Finally, in addition to prioritizing consumer choice and opportunity, strengths-based and recovery-centred support services and community and vocational integration, translating the HF philosophy and model into programs, practices and policies is essential.

DISCUSSION

The Ecological Context of Sustainability

The findings of this research demonstrate a high degree of sustainment of the HF programs across Canada. Nine of the 12 programs (75%) were sustained. In understanding both sustainability outcomes and the factors influencing sustainability, it is important to consider their ecological context. To this end we analyze the sustainability outcomes and factors influencing sustainability at the macro (federal and provincial governments), meso (community) and micro (program) levels.

Sustainability at the macro level

The interplay between HF programs at the macro level was largely the story of partnerships with provincial governments. Provincial partnerships varied with some sites like Toronto having a strong relationship with the provincial government while other programs like those in Montreal struggled to gain traction. These relationships translated directly into funding for housing and clinical teams and program expansion. Funding was a crucial part of sustainability and sites like Toronto that had traction with the provincial government were able to sustain all of their programs and keep teams intact.

Relationships with provincial governments were underpinned by broader funding and policy contexts which were strongly related to system integration factors. In some provinces there was a “disconnect” between HF practice, including emerging federal policy through HPS that promoted the model and provincial policy. At the same time, where congruence existed between HF practice and provincial policy (e.g. with Ontario’s Anti-Poverty Strategy and with BC’s ACT initiative), this provided a window for sustainability. Across sites, early “buy-in” from the provincial government was identified as a crucial factor influencing sustainability. As described in the national sustainability report (Macnaughton et al., 2016), early “buy-in” was established through the project’s Integrated Knowledge Translation strategy. By involving key provincial stakeholders and decision-makers at other levels actively in the research process, the sites were able to effectively convey the initiative’s successful results and gain policy “buy-in” for specific “asks.” In this regard, *leadership* was also an important factor influencing sustainability that facilitated provincial “buy-in.” Leaders included both senior staff like Site Coordinators from the programs, national research staff and local champions. Strong working relationships with policy-makers were identified as central to leadership in addition to the development of their specific “asks.”

Finally, funding HF programs implies a certain degree of systems coordination and the need to work across traditional silos to deliver coordinated housing and health services. Alignment between federal and provincial policy and flexible funding that works across silos will be crucial to the sustainability of emerging HF programs across Canada.

Sustainability at the meso level

At the meso, or community, level the crucial sustainability outcome was community-level partnerships. Strong relationships between HF agencies were identified as important in the process of sustainability. Community contextual factors were important in sites where participants needed to be transitioned into existing service to either fill gaps left by funding shortfalls or replace housing and clinical services altogether. Relationships with the broader service-provider community, landlords and municipal governments were crucial. Additionally, the local housing market and vacancy rates posed a challenge in locating affordable, high quality housing. Leadership was an important factor at the community level and the retention of program leaders was identified as a key to sustainability.

Sustainability at the program level

The key sustainability outcome at the program level was the fidelity to the HF model. Across sites, programs achieved relatively high fidelity scores. A common challenge was with regard to the Housing Process and Structure domain. The difficulty with housing demonstrates a direct link to the macro level in which funding had a tangible effect on the retention of staff and services. Housing teams were largely discontinued which impacted the ability of many programs to provide HF housing service to participants. Additionally, some sites described challenges in retaining staff and specialized services. Training and technical assistance was an important factor in smoothing staff turnover and orienting new staff to the HF model. Program leadership proved important in some sites like in Montreal where Diogène's ICM team leadership effectively negotiated sustained funding from Montreal's health authority. Finally, peer inclusion was an important factor influencing sustainability at the program level. Many sites were able to retain peer support workers who played important roles in advocating for participants and providing direct services at the program level.

Lessons Learned

There were some clear lessons learned about sustainability and HF programs from AHCS.

What worked well?

- Three-quarters (nine of 12) of the programs continued.
- Overall, fidelity to the HF model among those programs was good.
- Research findings were important for sustaining programs.
- Ongoing integrated knowledge translation and sustainability conversations with local, provincial and national stakeholders facilitated sustainability.
- Sustainability worked well when it was aligned with local and provincial policy
- Leadership and local partnerships for HF were important factors influencing sustainability.
- There is a need for ongoing training and technical assistance for HF programs.
- Facts, values, strategy and persistence were important for sustainability.

What worked less well?

- Loss of staff, as the initial program came to an end and there was uncertainty about employment, negatively impacted sustainability.
- Some provinces struggled with funding and inter-ministerial cooperation and had policy priorities other than HF.
- There was opposition to program expansion from congregate, supportive housing providers.

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APPENDIX 1

Housing First Fidelity Self-Assessment

Please select the answer choice that best describes the **housing process and structure** that this program offers its participants (Questions 1-7).

1. How does the program determine the type of housing in which a participant will live?

Program assigns participant to the first available housing unit	Program conducts a clinical assessment and determines the most appropriate housing based on participant's clinical need / functioning	Program assigns housing based on a clinical assessment, but with input from the participant regarding their preference	Participant chooses the type of housing they want to live in OR All participants have the option of a scatter-site apartment
1	2	3	4

2. How does the program determine the neighbourhood in which a participant will live?

Program automatically assigns participant to the neighbourhood with the first available housing unit OR all housing is in the same neighbourhood	Program conducts a clinical assessment and determines the most appropriate neighbourhood based on participant's clinical need / functioning	Program assigns housing based on a clinical assessment, but with input from the participant regarding their preference	Participant chooses the neighbourhood they want to live in, given what they can afford
1	2	3	4

3. Does the program assist participants with furniture?

Program does not assist participants with obtaining furniture	Program assists participants to find furniture in the community (e.g. donations)	Program assists participants by purchasing furniture
1	2	4

4. To what extent does this program have ready access to affordable housing through the use of housing subsidies?

Program does not have access to housing subsidies or subsidized housing units and does not provide support for participants to obtain them	Program does not have access to housing subsidies or subsidized housing units, but provides advocacy and support for participants to obtain housing subsidies or subsidized housing units	Program has direct access to housing subsidies and/or subsidized housing units, but there is a waiting period for participants	Program has ready direct access to housing subsidies and/or provides subsidized housing units for all participants
1	2	3	4

5. What percent of participants pay **30% or less** of their income towards their rent (excluding costs for other services such as food, housekeeping, and nursing) in permanent supported housing?

0-14%	15-29%	31-45%	46-60%	60-84%	85-100%
1	1	1	2	3	4

6. **On average**, how long does it take participants to move from enrollment into permanent housing?

Within 6 months	Within 6 months	Within 3 months	Within 2 months	Within 1 month	Within 2 weeks
1	2	3	4	4	4

7. What percent of participants live in the following housing types? (Fill in % for each.)

TYPE OF HOUSING	PERCENT
a. Emergency, short-term or transitional housing	____%
b. Hotel	____%
c. Congregate housing/group home	____%
d. Social housing; no support services	____%
e. Social housing; with support services on-site	____%
f. Social housing; with support services off-site	____%
g. Supportive housing (specialized housing for persons with psychiatric disabilities with support on-site)	____%
h. Independent apartments rented from community landlords	____%
i. Other housing type fill in:	____%

Please select the answer choice that best describes **how housing and services are related** in this program (Questions 8-13).

8. What percent of participants share a bedroom with other tenants?

0-14%	15-29%	30-44%	45-59%	60-84%	85-100%
4	4	3	2	1	1

9. What requirements do program participants have to meet *in order to gain access* to a permanent, independent scatter-site apartment? (Choose all that apply.)

Completion of a period of time in transitional housing, outpatient, inpatient, or residential treatment	Sobriety or abstinence from alcohol and/or drugs	Compliance with medication	Psychiatric symptom stability	Willingness to comply with a treatment plan that addresses sobriety, abstinence, and/or medication compliance	Agreeing to face-to-face visits with staff	Meeting responsibilities of a standard lease
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. What requirements do participants have to meet *in order to stay* in permanent housing? (Choose all that apply.)

Sobriety or abstinence from alcohol and/or drugs	Compliance with medication	Psychiatric symptom stability	Compliance with treatment plan and/or participation in formal treatment activities (attending groups, seeing a psychiatrist)	Agreeing to face-to-face visits with staff	Meeting responsibilities of a standard lease
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11a. Do the **majority of participants** have any lease or occupancy agreement that specifies their rights and responsibilities of tenancy?

Yes	No
<input checked="" type="radio"/>	<input type="radio"/>

11b. If **yes**, which of the following provisions does the lease or agreement contain? (**Choose all that apply.**)

Provisions regarding adherence to medication, sobriety and/or a treatment plan	Provisions regarding adherence to program rules, such as curfews	Provisions regarding adherence to face-to-face visits with staff	Provisions regarding creating behavioral disturbances with respect to other tenants
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12. Which statement best describes program actions **regarding housing** when participants lose their housing?

Program does not offer a new housing unit and does not assist participants with finding housing outside the program	Program does not offer a new housing unit, but helps participants find housing outside the program	Program offers participants a new unit after they meet readiness criteria, complete a period of time in more supervised housing and/or programs has set limits on the number of relocations	Program offers participants a new unit and decisions to re-house participants are individualized and minimize conditions that participants need to fulfill prior to receiving a new unit
1	2	3	4

13. Which statement best describes program actions **regarding services** when participants lose their housing?

Participants are discharged from services if they lose housing	Participants are discharged from services if they lose housing, but there are explicit criteria outlining options for re-enrollment	Participants continue to receive program services if they lose housing, but may be discharged from services if they do not meet certain criteria	Participants continue to receive program services if they lose housing
1	2	3	4

Please select the answer choice that best describes the **service philosophy** of this program (Questions 14-20).

14. How does the program determine the type, sequence and intensity of services on an ongoing basis?

Services are chosen by the service provider, generally based on clinical assessments and participant functioning	Participants have some say in choosing, modifying and refusing services, but staff determinations usually prevail	Participants have some say in choosing, modifying or refusing services and participant preferences usually prevail	Participants choose/modify/refuse services & supports at any time, except one face-to-face visit with staff a week
1	2	3	4

15. What are the requirements for participants with serious mental illness (SMI) to take medication or participate in psychiatric treatment such as attending groups or seeing a psychiatrist?

All participants with SMI are required to take medication and/or participate in treatment	Most participants with SMI are required to take medication and/or participate in treatment, but exceptions are made	Participants with SMI who have not achieved symptom stability are required to take medication and/or participate in treatment	Participants with SMI are not required to take medication and/or participate in treatment
1	2	3	4

16. What are the requirements for participants with substance abuse (SA) disorders to participate in SA treatment such as inpatient treatment, attending groups or counselling with a substance use specialist?

All participants with SA disorders, regardless of current use or abstinence, are required to participate in SA treatment	Participants with SA disorders who have not achieved a specified period of abstinence must participate in SA treatment	Participants with SA disorders who are currently actively using substances must participate in SA treatment	Participants with SA disorders are not required to participate in SA treatment
1	2	3	4

17. What is the program’s approach to substance use among participants?

Participants are required to abstain from alcohol and/or drugs at all times and/or program imposes negative for use (e.g. moving the person to more supervised housing)	Participants are required to abstain from alcohol and/or drugs while they are in their residence	Participants are not required to abstain from alcohol and/or drugs, but staff work with participants to achieve abstinence	Participants are not required to abstain from alcohol and/or drugs, but staff work with participants to reduce the negative consequences of use and/or utilize appropriate stage matched interventions
1	2	3	4

18. Which of the following activities does program staff use to promote adherence to a treatment plan? (Choose all that apply.)

Requiring urine screening	Paying participants to take medication	Requiring daily visits with staff	Caution the withholding of participant’s income/ allowance	Caution the withholding of participant services	Caution the withholding of participant’s housing	Engaging in quid pro quo
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

19. Which of the following are included in a participant’s treatment plan and follow-up? (Choose all that apply.)

Goals that are chosen by staff or automatically set by program	Goals that are chosen by staff with input from participant	Goals that are chosen by the participant with input from staff	Participant strengths	Barriers to achieving goals	Participant and program actions taken to support goals
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

20. Which life areas does the program systematically address with specific interventions?
(Choose all that apply.)

Interventions that target mental health and substance use symptoms	Interventions that target housing support	Interventions that target physical health	Interventions that target employment and education	Interventions that target financial needs	Interventions that target community integration, social support, spirituality, recreation
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please select the answer choice that best describes the **service array** of this program (Questions 21-29a).

21. What services does the program offer to help participants maintain housing such as offering assistance with neighbourhood orientation, landlord relations, budgeting and shopping?

Program does not offer housing support services	Program offers housing support services during move-in, such as neighbourhood orientation and shopping	Program offers ongoing housing support services, such as neighbourhood orientation, landlord relations, budgeting and shopping	Program offers ongoing property management services, assistance with rent payment and cosigning of leases
1	2	3	4

22. What types of psychiatric services, if any, are available to participants?

Program does not assist participants with access to psychiatric care	Program refers participants to psychiatrists or nurse practitioners in the community, but does <i>not</i> have formal or informal linkages with these providers	Program refers participants to psychiatrists or nurse practitioners in the community and <i>has</i> formal or informal linkages with these providers	Program has a psychiatrist or nurse practitioner on staff that provides services directly to participants
ACT 1	2	3	4
ICM 1	2	4	4

23. What types of services, if any, are available to participants who are in need of substance use treatment? (**Choose all that apply.**)

Substance use treatment services are not available	Systematic and integrated screening and assessment	Interventions/ Counseling tailored to participant's readiness to change	Outreach or motivational interviewing	CBT, relapse prevention, or other EBP or Promising Practice (e.g. BRITE)
0	0	0	0	0

24. What types of services, if any, are available to participants who are interested in paid employment opportunities?

Employment services are not available	Vocational assessment	Individualized short term employment (e.g. day labor)	In-house work experience or sheltered work (e.g. Goodwill)	Community-based employment
1	2	3	4	5

25. What types of services, if any, are available to participants who are interested in education?

Educational services are not available	Educational assessment	In-house education (e.g. literacy remediation)	Adult school, vocational training, trade school/ apprenticeship	Supported education in the community (e.g. community college)
1	2	3	4	5

26. What types of services, if any, are available to participants who are interested in volunteering?

Volunteering services are not available	Volunteering capability and interest assessment	Individualized short term volunteering	In-house volunteer experience or sheltered experience	Community-based volunteering
1	2	3	4	5

27. What types of services, if any, are available to participants who have medical (physical health) issues? (**Choose all that apply.**)

Medical/physical health services are not available	Screening for medical problems or medication side effects	Managing medication related to physical health	Communicating and coordinating services with other medical providers	Health promotion, prevention, education activities	On-site diagnosis and treatment of physical health conditions
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

28. Does the program have a **paid** peer specialist on staff who provides services directly to participants?

There is no paid peer specialist on staff	.25 FTE to .49 FTE peer specialist for every 100 participants	.50 FTE to .99 FTE peer specialist for every 100 participants	1.0 FTE peer specialist or more for every 100 participants
1	2	3	4

29a. What types of social integration services, if any, are available to participants? (**Choose all that apply.**)

Social integration services are not available	Basic social skills training (e.g. maintaining eye contact, holding a conversation)	Group recreational/leisure activities (lunches, sporting events, senior center)	One-on-one support for developing social competencies (e.g. help with empowerment, resolving problems with members of social network, establishing trust)	Services to help support or expand participants' social roles (e.g. employee/volunteer, sibling/parent/grandparent, neighbor)	Support for activities pertaining to citizenship or civic participation (e.g. help with advocacy, voting, community involvement, faith community involvement)
<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

29b. Generally, where do program services and opportunities for social integration occur?

Within the program/ program offices	Within the community	Both equally
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

30. What percent of participants have experienced a psychiatric hospitalization in the past 6 months?

0-14%	15-29%	30-44%	45-59%	60-84%	85-100%
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please select the answer choice that best describes the **team structure/human resources** of this program (Questions 31-37).

31. Do more than 50% of program participants have histories of any of the following? (**Choose all that apply.**)

Street Homelessness	Shelter Stays	Severe Mental Illness	Psychiatric Hospitalization	Substance Abuse/Dependence Disorders
<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

32. How does service staff operate with respect to caseloads?

Staff have individual caseloads (one staff member works regularly with a participant)	Staff have shared caseloads (multiple staff work regularly with a participant)
0	0

33. What participant/staff ratio does the program typically maintain, excluding prescribing MDs and nurse practitioners and administrative support?

36 or more participants per 1 FTE staff	26-35 participants per 1 FTE staff	16-25 participants per 1 FTE staff	11-15 participants per 1 FTE staff	10 or fewer participants per 1 FTE
ACT 1	1	2	3	4
ICM 2	3	4		

34a. Is there a policy regarding the minimum number of face-to-face contacts that participants are required to have with staff in a month?

No minimum requirement	1	2-3	4-5	6-10	11-14	15+
	0	0	0	0	0	0

34b. On average, what is the actual number of face-to-face contacts participants have with staff in a month?

<1	1	2-3	4-5	6-10	11-14	15+
ACT 1	1	2	4	4	4	4
ICM 1	1	4	4	4	4	4

35. How often do program staff meet to plan and review services for participants?

Program staff meet less than one day a month	Program staff meet 1 day per month	Program staff meet 1 day per week	Program staff meet 2-3 days per week	Program staff meet at least 4 days per week
ACT 1	1	2	3	4
ICM 1	2	4		

36. To what extent does the program use its team meetings to meet the following functions? (Choose all that apply.)

Conduct a brief, but clinically-relevant review of any participants with whom they had contact in the past 24 hours	Conduct a review of the long-term goals of all clients on a regularly scheduled basis	Develop a staff schedule based on participant schedules and emerging needs	Discuss need for proactive contacts to prevent future crises	Review previous staff assignments for follow through
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

37. What types of opportunities are available for participant input into program operations and policy? (Choose all that apply.)

Program has a formal grievance process for participants to express concerns or dissatisfaction	Program formally offers opportunities for participant feedback (e.g. community meetings)	Program routinely includes participants on planning/ implementation committees, advisory boards	Program employs persons with lived experiences in regular staff positions	Program includes participants on governing bodies
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

38. Is there anything else that you would like to mention that would be important to know about your program?

Citation: Gilmer, T., Stefancic, A., Sklar, M., & Tsemberis, S. (2013). Development and validation of a Housing First Fidelity survey. *Psychiatric Services*, 64 (9), 911-914.

APPENDIX 2

Scoring System for Housing First Fidelity Self-Assessment

SCORING NOTES (AS & GN)

I tried to stay in keeping with fidelity scale scoring and so used a 1-4 scale.

I broke out ACT vs. ICM scoring when applicable. When they ran the California program data, however, I believe they just scaled all programs along the ACT criteria.

No color; 1-4 ranking: 1= lowest fidelity, 4 highest (because of how we constructed the answer options to not always point to the right answer on the extremes, you'll see that multiple items can get you a 1 or a 4 because it surpasses the threshold).

Red color: These are choose all that apply; the more red items you choose, the lower the fidelity.

q.9: 5 red = 1, 4 red = 2, 3 red = 3, 2 red = 4, 1 red = 5, 0 red = 6

q.10: 4 red = 1, 3 red = 2, 2 red = 3, 1 red = 4, 0 red = 5

q.11b: 2 red = 1, 1 red = 2, 0 red = 3

q.18: 7 red = 1, 6 red = 2, 5 red = 3, 4 red = 4, 3 red = 5, 2 red = 6, 1 red = 7, 0 red = 8

Green color: These are choose all that apply; the more green items you choose, the higher the fidelity.

q.11a: 1 green = 2, 0 green = 1

q.20: 0 green = 1, 1 green = 2, 2 green = 3, 3 green = 4, 4 green = 5, 5 green = 6, 6 green = 7

q.23 and 27, 29a: 0 green = 1, 1 green = 2, 2 green = 3, 3 green = 4, 4 green = 5

q.31, 36-37: 0 green = 1, 1 green = 2, 2 green = 3, 3 green = 4, 4 green = 5, 5 green = 6

Red and green color:

q.19: 1 or 2 red + 0 green = 1, 1 or 2 red + 1 green = 2, 1 or 2 red + 2 green = 3, 1 or 2 red + 3 green = 4, 1 or 2 red + 4 green = 5, 0 red + 0 green = 6, 0 red + 1 green = 7, 0 red + 2 green = 8, 0 red + 3 green = 9, 0 red + 4 green = 10

Other:

q.7: A score of 4 would be 85% of participants living in fully integrated housing, 3= 60-84, 2=45-59% and 1=44 or less.

Scores for different domains

Housing Process and Structure – items 1-7, potential range 7-28.

Separation of Housing and Services – items 8-13, potential range 7-28.

Service Philosophy – items 14-20, potential range 7-41.

Service Array – items 21-29a, potential range 9-42.

Team Structure/Human Resources – items 31, 33-37 (skip 34a), potential range 6-30.

Total Score – potential range 36-169.

Note that the following items are not included in the scoring: 29b, 30, 32, and 34a..

APPENDIX 3

Document Review Protocol

Site _____

Title of Document _____

Date of Document _____

Date of Document Review _____

Name of Person Who Reviewed the Document _____

Author(s) or Voice(s) Represented in the Document _____

Topic Area	Noteworthy Descriptive Information	Reviewer Impressions/ Analytic Comments
Funding/budget		
Local-level partnerships		
Routinization of Housing First		
Expansion/dissemination of Housing First		
Staff retention and ongoing training		
Fidelity to the Housing First model		
Program adaptations		
Program outcomes		
Organizational support		
Local leadership		
Community context		
Policy and funding context		
Other noteworthy topics/ issues		

APPENDIX 4

Site Key Informant Recruitment Script for Participants

I am writing to invite you to participate in a research study on the sustainability phase of the *Mental Health Commission of Canada Homelessness and Mental Health Demonstration Project – Sustainability Research*. The purpose of this research is to understand the story of the sustainability of the MHCC At Home/Chez Soi programs. The term “sustainability” refers to continued funding for the rent supplements and ACT/ICM teams, maintenance of local-level partnerships, expansion/dissemination of Housing First (including changes in policy), staff retention and ongoing training, continued high levels of program fidelity and local adaptations of the Housing First model.

The findings of this research will be used to inform other jurisdictions that are interested in planning and sustaining similar initiatives. The Principal Investigators for this research project are [insert names]. Approximately 10 people who were key to the sustainability of At Home/ Chez Soi will be interviewed for this research. The Principal Investigators and the Site Coordinator for this site suggested that you would be a key person to invite to participate in this research. Please see the attached Information Letter for further details about the study.

Site Key Informant Information Letter

You are invited to participate in a research study on the sustainability of the Mental Health Commission of Canada's At Home/Chez Soi project in [site name]. The purpose of this research is to understand the story of the sustainability of At Home/Chez Soi in [site name], as you see it. The term "sustainability" refers to continued funding for the rent supplements and ACT/ICM teams, maintenance of local-level partnerships, expansion/dissemination of Housing First (including changes in policy), staff retention and ongoing training, continued high levels of program fidelity and local adaptations of the Housing First model.

The findings of this research will be used to inform other jurisdictions that are interested in planning similar initiatives. The Principal Investigators for this project are [insert names]. Altogether, between 50 and 100 people across the five demonstration sites will participate in interviews or focus groups for this research. This includes approximately 5-10 people who were key to the sustainability of the [site name] initiative participating in individual interviews and another 10-20 participating in focus groups.

Information

This research is part of the Mental Health Commission of Canada Research Demonstration Projects in Mental Health and Homelessness in [site name]. This aspect of the research involves participation in an individual interview. The interview will be conducted by a member of the local site research team. The interview will be arranged at a time and place that is convenient for you.

During the interview, the Site Researcher will ask you a number of questions about the sustainability of the MHCC At Home/Chez Soi project in [site name]. We will give you the questions in advance so you have a chance to think about them. You are free not to answer any question or to pass on any question that is asked. The interview will last for approximately one to one-and-one-half hours. With your consent, the Site Researcher will audio record the interview. There is no deception involved in the research.

Risks

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

Benefits

We do envision significant benefits to your participation in this study. You may benefit from the opportunity to reflect on your participation in the sustainability of the MHCC At Home/Chez Soi project in [site name]. Your perspectives on the sustainability of the project may be beneficial to other jurisdictions that are interested in planning similar initiatives. Finally, the results of this study will make a contribution to the research literature on the ways in which Housing First programs can be sustained in different community contexts.

Confidentiality

Your responses to the interview questions will be held confidential by the researcher. That is, your name will not be associated with anything you say during the interview. We will keep everything you say confidential and private and your name will not be associated in any way with your responses. A transcription of the interview will be identified by code number and stored in a locked filing cabinet to protect the confidentiality of your responses. Should you consent to the use of quotations from your interview, they may be used in write-ups and/or presentations on this research; however, the quotations will not contain any information that allows you to be identified.

All audio files of digitally recorded interviews will be stored on a secure (password protected) computer, which is accessible only to members of the local site research team. Transcriptions of the interviews will be stored in a locked filing cabinet [add location – probably the office of the site researcher]. All audio files will be deleted and paper transcripts destroyed by December 31, 2020.

Compensation

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

Contact

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

Participation

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

Feedback and Publication

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

Where can I get additional help or resources if I need them?

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

[Site Researcher name and contact information]

or

[REB name and contact information for local university]

Site Key Informant Consent Form

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

I agree to participate in the individual interview for this research. Yes _____ No _____

I agree to have the interview tape-recorded. Yes _____ No _____

I understand and agree that my quotations may appear in published reports. Yes ___ No _____

Participant's signature _____

Date _____

Researcher's signature _____

Date _____

Site Key Informant Interview Guide

Thank you for attending this interview. As you know, the purpose of this interview is for you to share your knowledge about the sustainability of the Mental Health Commission of Canada (MHCC) At Home/Chez Soi programs at your site.

For the purposes of this research, the term “sustainability” refers to continued funding for the rent supplements and ACT/ICM teams, maintenance of local-level partnerships, expansion/dissemination of Housing First (including changes in policy), staff retention and ongoing training, continued high levels of program fidelity and local adaptations of the Housing First model. Also, the questions that we will ask pertain to the time period between January-May 2012 (the time of the follow-up implementation and fidelity evaluation) and March 2015.

We believe that it is very important to understand program sustainability and how it is achieved or not achieved. The interview will take less than one hour.

Before we get started let’s review the consent form. Then you can decide if you want to participate in the interview. [Interviewer reviews the information letter and consent form with the participant.]

What questions do you have before we begin? [After questions have been asked and answered, the participant is asked to complete the consent form and give it to the interviewer.] I am now going to start the audio-recorder.

The purpose of today’s interview is to focus on what has changed in the MHCC At Home/Chez Soi programs at each project site since the end of the demonstration phase.

Sustainability Story

1. Please tell me the sustainability story for your site as you see it. (Probes re:)

What has been sustained? What hasn’t been sustained?

What has changed in terms how the program works with participants concerning their housing? What has changed in terms of the support provided by the program?

What strategies were used by your site and MHCC to promote sustainability?

Who were the main actors in the sustainability story?

How did the community context influence sustainability?

How did the policy and funding context influence sustainability?

What worked to promote sustainability? What didn't work?

Why were the programs continued in their original form, changed to a new form, or discontinued?

Dimensions of Sustainability (Note to the interviewer: some of these questions may have been answered in the previous section, check with the participant to see if she or he has more to add based on these questions.)

1. For each of the programs at your site, please describe funding of the programs since the end of the demonstration phase.
 - A. Please describe funding for housing subsidies/rent supplements. (Probe re: amount of funding, source of funding.)
 - B. Please describe funding for the ACT and ICM teams. (Probe re: amount of funding, source of funding.)
2. Where teams have not been continued, has there been any lasting impact of the At Home/ Chez Soi project on the original host agency or on the surrounding mental health system (e.g. on teams to which AH/CS clients have been referred?)
3. Please describe any changes that have occurred in local-level partnerships since the end of the demonstration phase. (Probe re: government, mental health partners, people with lived experience, housing partners, landlords, other partners.)
4. Describe the extent to which the Housing First programs have become a normal part of the service system at your site for homeless persons with mental health problems or illnesses. (Probe re: the organizations that sponsor Housing First; re any positive or negative impacts of HF programs becoming part of the regular system.)
5. Have there been efforts at your site to expand or further disseminate the Housing First approach? If so, please describe.
6. To what extent has there been staff turnover in the local teams that have impacted program sustainability? Describe ongoing training for programs that provide the Housing First approach.

7. In your opinion, how well have the existing or remaining Housing First programs maintained fidelity to the Housing First model? (Probe re: Housing Choice and Structure, Separation of Housing and Services, Service Philosophy, Service Array, Program Structure – note the interviewer will have to familiarize himself or herself with these domains of the Housing First fidelity scale.)

Factors Influencing Sustainability (Note to the interviewer: some of these questions may have been answered in the first section, check with the participant to see if she or he has more to add based on these questions.)

1. What strategies, actions, steps were taken to promote the sustainability of Housing First programs at your site? (Probe re: funding, fidelity of practice, partnerships and integration of HF into the regular system.)
2. Who was involved from your site and MHCC regarding these strategies, actions and steps?
3. Who has spearheaded sustainability efforts at this site?
4. What organizations supported sustainability efforts?
5. What was the target or focus of sustainability strategies, actions, steps?
6. Please describe the community context and how it facilitated or inhibited sustainability.
7. Please describe the policy and funding context and how it facilitated or inhibited sustainability.
8. What role did the research findings play in sustainability efforts?

Ending the Interview

Are there any other observations about the sustainability of At Home/Chez Soi that you haven't had a chance to mention that you would like to add before we finish?

As I bring this interview to a close I would like to know about your experiences (how you feel, what you are thinking) about having participated in this interview today/tonight.

Is there anything we could do to improve the interview? I am now shutting off the audio-recorder. What questions do you have of me?

APPENDIX 5

ACT/ICM Site Focus Group Recruitment Script for Participants

I am writing to invite you to participate in a research study on the sustainability phase of the Mental Health Commission of Canada's (MHCC) At Home/Chez Soi Demonstration Project. The purpose of this research is to understand the story of the sustainability of the MHCC At Home/Chez Soi programs. The findings of this research will be used to inform other jurisdictions that are interested in planning and sustaining similar initiatives.

The Principal Investigators for this research project are [insert names]. Approximately 10-20 people who were staff members of one of the At Home/Chez Soi teams at this site will be interviewed for this research. The Principal Investigators and the Site Coordinator for this site suggested that you would be a key person to invite to participate in this research. Please see the attached Information Letter for further details about the study.

ACT/ICM Site Focus Group Information Letter

You are invited to participate in a research study on the planning and proposal development of the Mental Health Commission of Canada Research Demonstration Project in Mental Health and Homelessness in [site name]. The purpose of this research is to understand the story of the planning and proposal development for the MHCC Homelessness and Mental Health Project in [site name], as you see it.

The findings of this research will be used to inform other jurisdictions that are interested in planning similar initiatives. The Principal Investigators for this project are [insert names]. Altogether, between 50 and 100 people across the five demonstration sites will participate in interviews or focus groups for this research. This includes approximately 5-10 people who were key to the sustainability of the [site name] initiative participating in individual interviews and another 10-20 participating in focus groups.

Information

This research is part of the Mental Health Commission of Canada Research Demonstration Projects in Mental Health and Homelessness, in which you have participated in the sustainability of programs in [site name]. This aspect of the research involves participation in a focus group. The focus group will be conducted by a member of the local site research team. The focus group will be arranged at a time and place that is convenient for you and other participants.

During the focus group, the Site Researcher will ask you a number of questions about the sustainability of the MHCC Homelessness and Mental Health Project in [site name]. We will give you and the other focus group participants the questions in advance so you have a chance to think about them. Everyone will have a chance to speak to each question; however, you are also free not to answer any question or to pass on any question that is asked. The focus group will last for approximately one hour. There will be a break, if the group wishes. With your consent, the Site Researcher will audio record the interview. There is no deception involved in the research.

Risks

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

Benefits

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

Confidentiality

Your responses to the focus group questions will be kept completely anonymous. That is, your name will not be associated with anything you say during the focus group. The Site Researcher will ask all participants to keep what is said in the group confidential. While we cannot guarantee complete confidentiality, as some participants may talk with others about their participation in the group, we as researchers will keep everything you say confidential and private.

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

All audio files of digitally recorded focus groups will be stored on a secure (password protected) computer, which is accessible only to members of the local site research team and the national site research team. Transcriptions of the interviews will be stored in a locked filing cabinet [add location – probably the office of the site researcher]. All audio files will be deleted and paper transcripts destroyed by December 31, 2020.

Compensation

No compensation will be provided for your participation in this focus group.

Contact

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

Participation

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

Feedback and Publication

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

Where can I get additional help or resources if I need them?

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

[Site Researcher name and contact information]

or

[REB name and contact information for local university]

ACT/ICM Site Focus Group Consent Form

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

I agree to participate in the focus group for this research. Yes _____ No _____

I agree to have the focus group tape-recorded. Yes _____ No _____

I understand and agree that my quotations may appear in published reports. Yes ___ No _____

Participant's signature _____

Date _____

Researcher's signature _____

Date _____

ACT/ICM Staff Interview Guide

Thank you for attending this focus group interview. As you know, the purpose of this interview is for you to share your knowledge about the sustainability of the Mental Health Commission of Canada (MHCC) At Home/Chez Soi programs.

For the purposes of this research, the term “sustainability” refers to continued funding for the rent supplements and ACT/ICM teams, maintenance of local-level partnerships, expansion/dissemination of Housing First (including changes in policy), staff retention and ongoing training, continued high levels of program fidelity and local adaptations of the Housing First model. Also, the questions that we will ask pertain to the time period between January-May 2012 (the time of the follow-up implementation and fidelity evaluation) and March 2015.

We believe that it is very important to understand program sustainability and how it is achieved or not achieved. The interview will take less than one hour.

Before we get started let’s review the consent form. Then you can decide if you want to participate in the focus group interview. [Interviewer reviews the information letter and consent form with the participants.]

Let’s begin by introducing ourselves to the rest of the group. [After introductions have been made.] I am now going to start the audio recorder.

The purpose of today’s discussion is to focus on the sustainability or continuation of your program. I will give everyone a chance to respond to each question. If you don’t want to give your opinions or voice your experiences about the question, feel free to pass.

Sustainability Overview

1. What has changed with your program in terms how the program works with participants concerning their housing?
2. What has changed in terms of the support provided by the program? What has remained the same with your program?
3. Why has the program continued in its original form, changed to a new form or discontinued?
4. What impact have the program changes had on staff, consumers and/or the service system?

Dimensions of Sustainability

1. Describe any changes in the funding for your program.
 - A. Please describe funding for housing subsidies/rent supplements. (Probe re : amount of funding, source of funding.)
 - B. Please describe funding for the clinical team. (Probe re: amount of funding, source of funding.)
2. Please describe any changes that have occurred in local-level partnerships since the end of the demonstration phase. (Probe re: mental health partners, people with lived experience, housing partners, landlords, other partners.)
3. Describe the extent to which your program has become a normal part of the service system at your site for homeless persons with mental health problems or illnesses. (Probe re: the organizations that sponsor Housing First; the positive and/or negative impacts of this.)
4. Have there been efforts at your site to expand or further disseminate the Housing First approach? If so, please describe.
5. To what extent has there been staff turnover in the local teams that have impacted program sustainability? Describe ongoing training for programs that provide the Housing First approach.
6. In your opinion, how well has your program maintained fidelity to the Housing First model? (Probe re: Housing Choice and Structure, Separation of Housing and Services, Service Philosophy, Service Array, Program Structure – note the interviewer will have to familiarize himself or herself with these domains of the Housing First fidelity scale.)

Factors Influencing Sustainability

1. What strategies, actions, steps were taken to promote the sustainability of your program? (Probe re: funding, fidelity of practice, partnerships, integration with the regular system.)
2. Who was involved from your program regarding these strategies, actions and steps?
3. Who has spearheaded sustainability efforts for your program?
4. What organizations supported sustainability efforts?

5. What was the target or focus of sustainability strategies, actions, steps?
6. Please describe the community context and how it facilitated or inhibited sustainability.
7. Please describe the policy and funding context and how it facilitated or inhibited sustainability.
8. What role did the research findings play in sustainability efforts?

Ending the Interview

Are there any other observations about the sustainability of your program that you haven't had a chance to mention that you would like to add before we finish?

As I bring this interview to a close I would like to know about your experiences (how you feel, what you are thinking) about having participated in this interview today/tonight.

Is there anything we could do to improve the interview?

I am now shutting off the audio-recorder. What questions do you have of me?

APPENDIX 6

Follow-Up Sustainability Research Recruitment Script for Participants

I am writing to invite you to participate in a research study on the sustainability phase of the Mental Health Commission of Canada's (MHCC) At Home/Chez Soi Demonstration Project. The purpose of this research is to understand the story of the sustainability of the MHCC At Home/Chez Soi programs. The findings of this research will be used to inform other jurisdictions that are interested in planning and sustaining similar initiatives.

The Principal Investigators for this research project are [insert names]. Approximately 10-20 people who were staff members of one of the At Home/Chez Soi teams at this site will be interviewed for this research. The Principal Investigators and the Site Coordinator for this site suggested that you would be a key person to invite to participate in this research. Please see the attached Information Letter for further details about the study.

Follow-Up Sustainability Research Information Letter

You are invited to participate in a research study on the planning and proposal development of the Mental Health Commission of Canada Research Demonstration Project in Mental Health and Homelessness in [site name]. The purpose of this research is to understand the story of the planning and proposal development for the MHCC Homelessness and Mental Health Project in [site name], as you see it.

The findings of this research will be used to inform other jurisdictions that are interested in planning similar initiatives. The Principal Investigators for this project are [insert names]. Altogether, between 50 and 100 people across the five demonstration sites will participate in interviews or focus groups for this research. This includes approximately 5-10 people who were key to the sustainability of the [site name] initiative participating in individual interviews and another 10-20 participating in focus groups.

Information

This research is part of the Mental Health Commission of Canada Research Demonstration Projects in Mental Health and Homelessness, in which you have participated in the sustainability of programs in [site name]. This aspect of the research involves participation in a focus group. The focus group will be conducted by a member of the local site research team. The focus group will be arranged at a time and place that is convenient for you and other participants.

During the focus group, the Site Researcher will ask you a number of questions about the sustainability of the MHCC Homelessness and Mental Health Project in [site name]. We will give you and the other focus group participants the questions in advance so you have a chance to think about them. Everyone will have a chance to speak to each question; however, you are also free not to answer any question or to pass on any question that is asked. The focus group will last for approximately one hour. There will be a break, if the group wishes. With your consent, the Site Researcher will audio record the interview. There is no deception involved in the research.

Risks

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

Benefits

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

Confidentiality

Your responses to the focus group questions will be kept completely anonymous. That is, your name will not be associated with anything you say during the focus group. The Site Researcher will ask all participants to keep what is said in the group confidential. While we cannot guarantee complete confidentiality, as some participants may talk with others about their participation in the group, we as researchers will keep everything you say confidential and private.

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

All audio files of digitally recorded focus groups will be stored on a secure (password protected) computer, which is accessible only to members of the local site research team and the national site research team. Transcriptions of the interviews will be stored in a locked filing cabinet [add location – probably the office of the site researcher]. All audio files will be deleted and paper transcripts destroyed by December 31, 2020.

Compensation

No compensation will be provided for your participation in this focus group.

Contact

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

Participation

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

Feedback and Publication

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

Where can I get additional help or resource if I need them?

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

[Site Researcher name and contact information]

or

[REB name and contact information for local university]

Follow-Up Sustainability Research Consent Form

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

I agree to participate in the focus group for this research. Yes _____ No _____

I agree to have the focus group tape-recorded. Yes _____ No _____

I understand and agree that my quotations may appear in published reports. Yes _____ No _____

Participant's signature _____

Date _____

Researcher's signature _____

Date _____

Consumer Focus Group or Individual Interview Guide for Sustainability Research

Thank you for attending this focus group interview. As you know, the purpose of this interview is for you to share your knowledge about the sustainability or continuation of the Mental Health Commission of Canada (MHCC) At Home/Chez Soi programs.

For the purposes of this research, the term “sustainability” refers to continued operation of the program as you knew when you first became involved with At Home/Chez Soi. Also, the questions that we will ask pertain to the time period between January-May 2012 (the time of the follow-up implementation and fidelity evaluation) and March 2015.

We believe that it is very important to understand program sustainability and how it is achieved or not achieved. The interview will take less than one hour.

Before we get started let’s review the consent form. Then you can decide if you want to participate in the focus group interview. [Interviewer reviews the information letter and consent form with the participants.]

Let’s begin by introducing ourselves to the rest of the group. [After introductions have been made.] I am now going to start the audio recorder.

The purpose of today’s discussion is to focus on the sustainability or continuation of your program. I will give everyone a chance to respond to each question. If you don’t want to give your opinions or voice your experiences about the question, feel free to pass.

Questions for Participants Who Continue to Receive ACT, ICM and Rent Supplements

1. Have the support services that you receive from this program changed in any way? If so, how have they changed?
2. Are there particular parts of the support services that you wish were still available to you?
3. Please describe any new support services that you receive.
4. What impact have the changes in support services had on you?
5. Has your housing changed in any way? If so, how has it changed?
6. Are there particular parts of the housing services that you wish were still available to you?
7. What impact have the changes in housing services had on you?

8. Are there some aspects of the housing and support services that you receive from this program that have remained the same? If so, please describe.
9. Describe what you like and find helpful about these housing and support services.
10. Describe what you don't like and find unhelpful about these housing and support services.

Questions for Participants Who Continue to Receive Rent Supplements, but not ACT or ICM

1. Please describe what it was like for you when the support services that you received were discontinued or changed?
2. Are there particular parts of the support services that you wish were still available to you?
3. Please describe any new support services that you receive.
4. What impact have the changes in support services had on you?
5. Has your housing changed in any way? If so, how has it changed?
6. Are there particular parts of the housing services that you wish were still available to you?
7. What impact have the changes in housing services had on you?
8. Describe what you like and find helpful about your current housing and support services.
9. Describe what you don't like and find unhelpful about your current housing and support services.

Ending the Interview

Are there any other observations about the sustainability of your program that you haven't had a chance to mention that you would like to add before we finish?

As I bring this interview to a close I would like to know about your experiences (how you feel, what you are thinking) about having participated in this interview today/tonight.

Is there anything we could do to improve the interview?

I am now shutting off the audio-recorder. What questions do you have of me?

CONTACT



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