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## **‘At Home/Chez Soi’ Implementation Evaluation Toronto Site Report**

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## I) Introduction

The At Home/Chez Soi research demonstration project is a complex health intervention that explores “Housing First” approaches to improving the lives of clients who experience both homelessness and serious mental health problems. The project is funded by the Mental Health Commission of Canada (MHCC) and builds on existing evidence and knowledge in the field, and applies it to the Canadian context. The At Home/Chez Soi Project is occurring in five cities across Canada: Moncton, Montreal, Toronto, Winnipeg, and Vancouver. Each of these sites has a specific target population or sub-study; these are rural and francophone, social housing, ethnoracial, aboriginal, and homeless people with concurrent disorders. The project aims to develop evidence on effective services and interventions for homeless people with mental health problems, and will help inform policy and programming to end homelessness in Canada.

This report describes findings from the Implementation Evaluation phase of the Toronto Site. It describes the context and pathways by which the MHCC intervention works (refer to Appendix A for description of local project context: site description, characteristics of homelessness situation, and description of Care as Usual). The purpose of this report is three-fold: (1) to highlight key program components for the Housing First/ACT and Housing First/ICM models, as well as the unique anti-racism/anti-oppression (AR/AO) framework utilized by the Housing First/Ethnoracial ICM intervention; (2) to describe the process of implementation at the Toronto Site, including its context, relationships, structures and resources; and, (3) to highlight ongoing program adaptations and innovations in response to changes in the larger community environment.

The Implementation Evaluation builds on the completed planning and proposal development research phase, as well as program logic models that have been developed for the Toronto Site. This data will also support ongoing routine technical assistance and training activities both locally and nationally. The Implementation Evaluation covers the processes that occurred at the Toronto Site from end of the October 2009 to January 2011.

## II) Methodology

### **a) Sample**

Participants were identified through consultation with the Principal Investigators and members of the Toronto Site project governance structure. A total of sixty-six participants completed key informant interviews or focus groups for the *Implementation Evaluation* of the Toronto Site At Home / Chez Soi project. Participants included stakeholders who played an integral role in the overall implementation of the Toronto Site At Home/Chez Soi Project; those involved in the implementation of the Third Intervention Arm; as well as consumers in both the intervention and control arms of the study. Interviews were conducted from December 2010 to January 2011.

Table 1 illustrates the number of participants in the implementation evaluation by role as either having participated in a key informant interview or a focus group.

Table 1. Participants by role

Type of Interview	Role Played	Total
Key Informant	<ul style="list-style-type: none"> <li>• Principal Investigator for the Toronto Site</li> <li>• Toronto Site Coordinator</li> <li>• Representative from the City of Toronto and its Housing Team</li> <li>• Directors from the ACT, ICM, and Ethnoracial ICM teams respectively</li> <li>• Team leads from the ACT, ICM, and Ethnoracial ICM teams respectively</li> </ul>	9
Focus Group	<ul style="list-style-type: none"> <li>• 3 with staff from the ACT (n=6), ICM (n=5), and Ethnoracial ICM teams (n=7) respectively</li> <li>• 1 with staff from the Housing Team (n=4);</li> <li>• 3 with clients of the ACT (n=6), ICM 9 (n=6), and Ethnoracial ICM teams (n=10) respectively</li> <li>• 1 with members of the PWLE Caucus (n=12)</li> <li>• 1 with participants from the Treatment as Usual (TAU) group (n=5).</li> </ul>	9

Specifically, nine key informant interviews were conducted with individuals directly involved in implementation: four key informant interviews were held with directors of the four project teams (ICM, ACT, ER-ICM and Housing); three key informant interviews were held with team leads for each of the Support Services Teams (ICM, ACT, and ER-ICM); additional key informant interviews were held with the Coordinator of the Toronto Site (hereafter referred to as the “Site Coordinator”) and a principal investigator from the Toronto Research Team.

A total of nine focus groups were also conducted: four with staff from each of the Support Services Teams and the Housing Team; three with clients of each of the respective Support Services Teams; 1 focus group was conducted with participants in the Treatment as Usual group; and an additional focus group was held with members of the Toronto Person’s With Lived Experience Caucus (hereafter referred to as the “Consumer Caucus”) affiliated with the study. The majority of participants were involved in more than one aspect of implementation, including involvement in project governance and service delivery.

The study was approved by the St. Michael’s Hospital Ethics Review Board and all participants provided written informed consent and agreed to have the interviews audio-recorded. Interviews and focus groups ranged from approximately one to two hours in length and were conducted by an interviewer who was not involved in project implementation. Focus groups with clients and participants from the Treatment as Usual group were co-facilitated by a representative from the Consumer Caucus. Project participants and members of the Caucus each received an honorarium of \$25 for their participation in a focus group.

## ***b) Coding, Analysis and Quality Assurance***

Interview and focus group transcripts were analyzed using grounded theory methodology which employs inductive strategies and comparative analysis to develop categories to explain data, and to identify patterns and relationships (Charmaz 1990; Glaser & Strauss 1967). Transcripts were analyzed by the study interviewer, in conjunction with a Principal Investigator, using NVIVO software. The process of analysis involved multiple readings of transcripts to identify key concepts, labeled “codes”. These codes were then compared within and between transcripts to ensure consistency. Similar codes were then grouped into themes, supported by direct quotations from the transcripts. Additionally, field notes were recorded by the interviewer upon completion of each interview and focus group; these notes served to support and elaborate upon the themes from the key informant interview and focus group data. Both the interviewer and Principal Investigator coded two key informant interview and focus group transcripts independently and compared their findings. Once consensus was achieved, the study interviewer proceeded to code the remaining transcripts. At this stage, a larger group of qualitative researchers from the team met on two occasions to discuss the categories and to collectively reduce the categories to a smaller set of higher-level themes.

Once a set of higher-level themes was developed, a meeting of the larger qualitative team, including the study Principal Investigators, was held to ensure that the themes faithfully reflected the important implementation processes that occurred at the Toronto Site.

## **III) Findings**

Findings from the Implementation Evaluation are presented in three parts: Part One examines participants’ perspectives on key elements of the At Home Chez/Soi Project models; Part Two describes themes related to project implementation; and, Part Three describes findings related to developmental processes that have occurred at the Toronto Site.

### **Part One: Project Models**

Evaluation is an opportunity to better understand a project’s activities and underlying assumptions, specifically the processes by which change is believed to occur for participants in the treatment arm of At Home/ Chez Soi project (hereafter referred to as “clients”). As part of the Implementation Evaluation, key informants and focus groups members were asked to (1) identify the key elements of both the “Housing First” and “Anti-racism/Anti-oppression” models as they relate to project structure and core features of service delivery; and, (2) articulate the underlying theory or mechanisms of change upon which services are based. The following section describes these key elements and mechanisms of change as described by our participants.

## **a) Housing First: Critical Ingredients and Mechanisms of Change**

The “Housing First” model aims to provide services to individuals who are marginalized by the existing fragmented and poorly-coordinated system of care (refer to Appendix B for Housing First Logic Model). The model provides immediate access to permanent housing and support services, guided by a philosophy of consumer choice. In the At Home Chez/Soi Project, housing, treatment, and other supports services are comprehensive and delivered in a coordinated manner in order to meet the needs of clients and to facilitate their recovery.

*“[Participants] are welcomed into this project and every effort is made once they are determined to be eligible to not only provide them with timely accommodation that both meets their needs...but also provide a really sustained support to help them maintain that accommodation.”*

Housing is provided primarily in scattered-site private market apartments. Treatment and support services are provided off-site (i.e. are not attached to the housing) and are focused on helping clients maintain housing and to integrate into the community by addressing mental health and recovery goals. As one client focus group participant described,

*“I guess the primary thing would be the housing bit really. I mean, the housing is amazing! I am just like these brothers over here, I mean being on the street it’s, it’s just and the shelter is not much better. It’s like an insane asylum...so it’s really good to get yourself some housing, and then after that then you can start getting on your, you know, like you can just stabilize, you can get on your medication, if that’s your thing or you could go back to school you know, that’s what I am going to be doing in February.”*

In Toronto, “Housing First” is achieved through the collaboration of distinct housing and service providers. Housing units are secured by a Housing Team while support services are provided by the three Support Services Teams (ACT, ICM, and ER-ICM).

### **i) Housing Services**

The following key elements of the housing process were identified and are described in this section: eliminating barriers to housing access; rent supplement availability; and, continuous engagement from homelessness-to-housed; together, these elements were thought to enhance the individuals’ sense of choice, dignity, and control.

Although “Housing First” is a novel approach to providing supports and services to individuals experiencing homelessness and serious mental health problems, as one key informant noted, the underlying treatment philosophy is regarded as having “*existed for some time*”. This include, eliminating barriers to housing access and providing individuals experiencing homelessness and serious mental health problems with the same rights and responsibilities of tenancy as any other individual. One of the ways this is achieved is by explicitly not requiring clients to show “*housing readiness*”, such as demonstrating sobriety or compliance with medication, as contingencies of tenancy.

*“...we have been doing ‘Housing First’ for a while, we totally get that it is effective in the sense that... very clearly research shows that people don’t need to go through a process of having transitional housing and learning housing skills and all that kind of stuff. I mean, it doesn’t make sense... so house them, [then] figure out what they need in order to keep them housed...”*

Key informants also add that while some clients will fail, as evidenced by either eviction or choosing to leave housing, many more clients will succeed.

Individuals who are randomized into the treatment arm of the study are eligible for a housing subsidy of up to six hundred dollars per month to supplement government income supports. This model of funding aims to maximize housing affordability for the individual, ensuring that they spend thirty percent or less of their income on rent. Both key informants and staff focus group participants identified the rent supplement as a central feature in eliminating affordability as a barrier to housing. As one client focus group participant noted,

*“The amount of subsidy a month is great because that helps us out with um, the 600 a month helps us so we can afford [housing]. The insurance is paid for as well and um, they help with the utilities as well... it’s a lot of help, it’s a lot of support, and uh, it is good old fashion a lot of money is what it is.”*

Several key informants and focus group participants felt that the rent supplement also plays an essential role in enhancing the choices available to clients in selecting their accommodations. It is portable and attached to the individual, not a particular housing site. This provides clients with a sense of control over decisions about their accommodations.

*“[T]he person doesn’t have to move specifically somewhere into a slot that’s open...in a building with other people in a similar situation... they can choose the neighbourhood in the city; they can choose a neighbourhood they are familiar with ;or, they may choose to get away from a neighbourhood that’s been problematic for them.”*

One key informant also regarded the rent supplement as a means of allowing people to live with dignity in accommodation that is, “usual for people who do not have mental health needs or who have not been homeless”. Other key informants described the rent supplement as a mechanism for reducing the impact of the “cycle of un-wellness” that is precipitated by limited access to funding supports, resulting in the individual having to make decisions to live in “questionable” and “dangerous” housing, often dealing with “slumlords” offering inadequate facilities.

Offering clients a choice in their housing options is regarded as contributing to their sense of control, or “mastery”, which in part helps foster a greater sense of personal attachment and belonging to their homes (Tsemberis, Gulcur, & Nakae, 2004).

*“[Recovery] can be a lot of baby steps together. And something like finding and having an affordable, normalized, accommodation where you begin to feel that*

*you are worth something... you're worth fighting for, can be very empowering."*

Decisions about accommodations are made by the clients upon entering the project and are facilitated by staff from one of the three Support Teams, who continue to engage them from homelessness to becoming housed. As one key informant noted, this process facilitates "*trust-building*" between staff and their clients. Further, satisfying housing choice is seen to significantly contour early engagement experiences between the two groups.

## **ii) Support Services**

The following key elements of service provision were identified and are described in this section: promoting self-determination and independence; training and supervision of staff to deliver quality care as evidenced by good clinical judgment, creativity and empathy; recognizing recovery as a spectrum; the use of motivational interviewing to promote recovery oriented goals; direct or brokered access to primary and psychiatric care; and, maximizing opportunities for community integration.

According to the project model, support staff work with clients in five areas that are believed to be critical to their recovery from homelessness and mental health problems. These are (1) providing them with immediate assistance in applying for public assistance and organizing their financial affairs to meet apartment lease eligibility requirements and to help them prepare and manage their household; (2) developing an immediate working alliance with clients in order to help them identify their treatment goals; (3) assisting them in identifying and accessing community health services for acute and chronic conditions; (4) working with them to understand and act on their job interests and job acquisition goals; and, (5) helping clients establish family, social, and spiritual connections as desired.

Key informants and focus group participants identified three major underlying themes with several sub-themes relating to these activities: (1) Providing client-driven care; (2) Enhancing access and quality of care; and, (3) Recovery orientation. These themes are described below.

### **(1) Client-Driven care**

A number of key informants regarded client-driven care as a "*critical component*" of service delivery, as it offers clients a level of self-determination over their receipt of services, and is believed to further their sense of control. As one key informant described, ensuring that services remain individualized begins with working with clients to develop a care plan that addresses their particular needs, while respecting their readiness/willingness to engage. Others described client-driven care as "*working where they are*". As one key informant noted,

*"Well, I think a lot of it has to do with the relationship [that] the client and the staff develop... the support and hopefully the goal-setting and kind of checking in with the clients in terms of what it is that they are wanting to achieve in terms of their goals...So, I think being supported and being given the proper advice,*



*hopefully whatever access there is in terms of what is available out there... being connected to those activities will help.... in achieving those outcomes.”*

Support staffs are required to respect the client’s priorities, even if they differ from those of the staff. For example, clients are not required to take part in psychiatric or substance use treatment. As one staff focus group participant said,

*“...that’s the goal, it’s not my goal, I mean if it’s their choice and it improves their quality of life and etc., but if they choose that this is not the right time, and I would rather be on the street, or I would rather continue with my activities that doesn’t help maintain that housing, I don’t necessarily see that as a failure, I see that as a learning opportunity and supporting them in continuing to look at what other opportunities there are.”*

In general, as one key informant noted, the process of engagement has been described as occurring, *“through trial and error, having opportunities to try things, whether they succeed or not, but then to help clients evaluate those choices and make changes”*.

## (2) Enhancing Access and Quality of Care

A number of key informants identified several elements that are necessary to ensure access and quality of care for clients. For example, clinical judgment and creativity were highlighted as necessary for successful engagement. Other key characteristics include the support staff’s ability to communicate and empathize with clients. Several key informants also described the importance of setting limits with clients, but also maintaining flexibility when working with them.

*“I think that it’s very easy for us to set it up so the clients fail and so there’s this really fine line between not being run over by a client but also not just saying oh yeah, sure... not being so rigid that you’re guaranteeing that the client isn’t going to be able to meet you halfway.”*

Both key informants and focus group participants described engagement encounters that used motivational interviewing techniques; or creative ways to assist clients in identifying their “goals and resources” while focusing on “self determination and independence”. As one staff focus group participant described,

*“I think we take as much as we can, an empowerment stance...we’re not going to do that for them or, we will do it with them, we’ll sit beside them, we’ll coach them, we’ll guide them, we’ll do role play, we’ll whatever but we’re not going to in, in most circumstances we’re not just going to go rescue them, we’re not rescuers.”*

They add that, for clients who are ready to address their mental or physical health concerns, referring them to the “right doctors” is an important first step. In this regard, both key informants and focus group participants identified access to a psychiatrist or a primary care

physician either directly through the ACT Team, or as a “brokered service” through the ICM model, as a key facilitator of recovery.

In general, the ACT Team is able to provide individuals with high needs with direct support from a staff of social workers, psychiatrists, psychiatric nurses, job development specialists, and a primary care physician. The ICM team consists of case managers with on-site access to psychiatrists and a primary care physician; staff “broker” with other providers in the community for additional support services for individuals with moderate needs.

### (3) Recovery Orientation

Working with clients on their recovery goals is described by one key informant as, “*part, and parcel of the encouragement and support of the individual*”. As part of the recovery orientation, the project model requires active engagement through regular contact between staff and the client. Both key informants and focus group participants also regarded recovery as a “*spectrum*”, and identified a variety of recovery goals amongst clients. For example, as one key informant noted, many clients have expressed a “*readiness*” to address their mental health issues, and the combination of clinical support and housing is seen to help move them along the stages of their recovery. They described the process for the clients as,

*“...when they’ve moved in and they’ve settled in and they get a lot of support is when they go, you know what? I am talking to myself a lot, like it’s just like they’ve never ever thought about it, it’s just that I am in the room alone and I am able to hear this so I know, I know I’ve got to take care of myself.”*

Another recovery goal amongst clients is community integration. Support staffs facilitate this process by helping clients identify and connect with their support networks. One staff member described this process as,

*“...helping define, what it is that will help the client get back into the community setting or the community life and, and then working with them to assist them in, in getting to that point whatever that may be.”*

Both key informants and focus group participants described connecting clients with volunteer opportunities as a way to facilitate their social recovery. As one client focus group participant noted,

*“...they were the ones who helped me to do it because um, you know, I was just too busy trying to stay warm you know, and trying to, to eat so I mean I really appreciate the, the [the project]. They made it so now I can concentrate on things like going to school...what’s next is learning to build relationships you know, because, you know, you have the strangest relationships when you’re homeless you know, very strange and they change like that right? So, it’s really good to of have one foot in the mainstream of society, that’s what’s really important to me.”*

Staff also described helping clients to reconnect with family as part of their recovery. This was primarily noted amongst ethnoracial clients. One key informant observed that, amongst those who wished to reconnect with family members, a lower incidence of crisis was seen when that choice was satisfied. They described this experience as,

*“When people get what they want...and there’s no crisis, if people want to live near their parents, near the sister, near the brother, the, the crisis can now go down, there’s no problem, like people settling in really good.”*

In general, the working relationship is regarded as catalyst for social recovery, in part aided by maximizing opportunities for community integration.

## **b) Anti-Racism Anti-Oppression Framework**

The Third Intervention Arm of Toronto’s At Home/Chez Soi project combines the Housing First philosophy with an anti-racism/ anti-oppression (AR/AO) framework in order to engage and provide support services to clients from racialized groups experiencing homelessness and serious mental health problems (refer to Appendix C for Third Intervention Arm Logic Model).<sup>1</sup> The AR/AO philosophy is built on three core values: that racism and oppression have profound negative effects on health and mental health; that clients need to heal in ways that are meaningful and relevant to them; and that racism and oppression can occur at individual, and system levels and that intervention is needed at both levels (Sarang, O’Campo & Durbin et al., 2009).

Given the unique barriers faced by homeless individuals and by those from racialized communities in accessing and engaging with health and social service providers, the combination of the Housing First framework with an AR/AO philosophy and practice is regarded as a useful approach to improving the health, housing stability and quality of life for homeless clients with mental health problems from racialized groups.

Key informants and focus group participants from the Third Intervention Arm identified congruence between the Housing First philosophy and the AR/AO framework that informs their unique service delivery model. Specifically, a commitment to client-driven recovery is an underlying value that informs both models. As one key informant noted,

*“I know that recovery is a big part of this model as well ... recovery really aligns very well to the anti-oppression framework and ... we talk about racism and discrimination and name it which talks about choice and talks about people’s hope and recovery.”*

The combined program model for the Third Arm adheres to both the Housing First philosophy and AR/AO practice and begins with the identification of individuals who are eligible for the Ethnoracial Intensive Case Management program (ER-ICM). The following section highlights key elements of the AR/AO framework and underlying theories of change for the Third

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<sup>1</sup> Consistent with the Statistics Canada employment equity category of ‘visible minority’, racialized group members are persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in Colour.

Intervention Arm. Specifically, agency supports for AR/AO and staff AR/AO practices are described.

### **i) Agency Supports for AR/AO**

The following elements relating to agency supports were identified and are described in this section: a formalized commitment to AR/AO practices by the agency; supervisory and administrative staff with relevant experience in AR/AO practice; identifying and labeling racism and oppression at the workplace; a commitment to hiring and ongoing training of staff from the communities served by the agency; and advocacy for system-level changes.

Agency support for an anti-racism and anti-oppression orientation begins with a formalized commitment to effective implementation of anti-racism practices to address intersecting forms of oppression, including homelessness, race, ethnicity, sex, gender, and sexual orientation. Having supervisory and administrative staff with relevant experience enhances the likelihood of the accessibility and use of AR /AO practice (Sarang, O'Campo & Durbin et al., 2009).

*“Staffs need the culture or the freedom to speak about the issues of the racialized clients... managers or the supervisors need to have that analysis and that understanding so then they are able to help support the staff in terms of how they work with the client. ... [If not] then the staff get to a point where they stop raising the issue, and they do the best they can but then it becomes that one off piece right? It doesn't become organizational support to racialized clients.”*

Hiring and retaining professional staff members who are from the ethnoracial backgrounds of clients allows for role modeling clients, and affords additional opportunities to increase knowledge about the lived experience of individuals from the communities that are served. . According to one key informant, staff should be capable of engaging clients on “*issues of race and oppression*”; and should be able to identify and “*label*” or “*name*” these experiences. They describe this process as,

*“[Staff] need to be able to speak to [issues of race and oppression] and if the organization support isn't there and the culture isn't there, then you're kind of missing the boat a little bit...So, if you're not able to name the issue and if you can't chat with the client about their experiences then you are not really addressing it...”*

AR/AO approaches are distinguished by their attention to issues of power as expressed within organization structures, as well as the staff-client relationship. According to participants, both staffs and clients should have a “voice”, and be able to have their concerns heard by management and influence decision-making. Staffs also emphasized the need to be able to debrief about their own experiences of discrimination; and to have formal mechanisms of complaints for both staff and clients.

*“I get a call from the worker saying “Oh my God, we had such a bad experience I think the client is going to go to do something bad today”, and I said “What do you mean?” So, she said “Well, the, the superintendent treated us really badly, it was a white women, she wanted to know are you on drugs ... it’s people like you that I have a problem renting to, I am going to check your criminal record, I am going to check your financial records” ...it became a little bit of a race issue... I said you know, we will put it writing and make a complaint...I will forward it to housing and the staff also, she was crying a lot on the phone, she’s never been treated like, she’s seen clients get treated like this but now she said both of us got treated really bad and so I was able to say what do you think that was, and they were like that was racism, they just didn’t understand why we you know, we’re making a big deal.”*

In general, the capacity and ‘openness’ of management to engage staff on these issues is regarded by both key informants and staff focus group participants as essential to ensuring the quality of organizational support for staff .

Providing a service environment that is welcoming and inclusive to racialized communities is also regarded as necessary in order to address experiences of exclusion and enhance notions of citizenship or belonging amongst these groups. As one key informant noted, this is achieved, in part, by offering linguistically and culturally accessible programs and services within a “safe and open” space, where representation of the diversity of ethno racial groups amongst service users are displayed.

Key informants also described agency involvement in advocacy for system-level changes to address the needs of racialized groups. Anti-racist approaches and analyses are seen to highlight inequitable inter-group social dynamics, and support empowerment processes that are critical to health and well-being. Such an approach to health requires that communities are engaged and mobilized, and that systemic issues beyond the agency’s immediate control are addressed through collaborative advocacy efforts.

## **ii) AR/AO Staff Practices**

Anti-racism and anti-oppression values are also manifest at the service delivery level as staffs translate theory into frontline practice in ways that inform not only program service options, but also their delivery. The following key elements related to staff practices were identified and are described here: asking explicitly about experiences of racism and oppression to facilitate planning and action to address experiences of discrimination; and, a holistic approach to health and wellness.

A client-driven philosophy helps to create the space required to engender trust in the working relationship. Using techniques of motivational interviewing, and by sharing their own past experiences, staffs encourage clients to speak explicitly about discrimination, and help them to name racism or oppression where they may have encountered it. . One staff focus group participant described this as, “...giving [clients] the opportunity... letting them know they can talk about [racism and discrimination].”

In this way, clients are empowered to discuss the multiple forms of oppression they have experienced. These discussions are used as entry points to engage in planning and action to address the experience, mitigate the impact of the experience, and provide them with the tools to recognize future experiences and address them without internalizing them. Discussions about racism and oppression are also used to engage clients on issues related to mental health, acknowledging the systemic impact of racism (e.g., negative experiences related to accessing employment, housing, and medical treatment) (Sarang, O'Campo & Durbin et al., 2009).

For example, one staff member observed that for many of her clients, race, homelessness, and mental health get “*mixed up*” when dealing with landlords. A number of staff members highlighted the experiences of clients who were turned down for units after they met the landlord. Staff responded by working to identify why these experiences were discriminatory; putting the experience into perspective so that the clients did not internalize or blame themselves; submitting a formal complaint about the discriminatory experience; and, working with clients to find a unit that was more conducive to their recovery.

Finally, service delivery is informed by a holistic approach to health and wellness. Clients are encouraged to access a range of treatment and support options that address both social and cultural determinants of health. For example, clients are able to cook and eat on-site in a community kitchen which fosters a community environment and facilitates learning, skill development, sharing of stress and healing. As one key informant described,

*“...we have a space that [clients] can come to, that’s the best part is they’re able to come to the centre because it’s a drop in...where people can eat, people when they eat they feel better...the drop in really works, the drop in, people just dropping in and hanging out, watching some TV, playing this, just talking that’s what making this work.”*

Numerous and innovative alternative healing programs are also offered (from news groups and yoga to drumming circles). This approach is grounded in an acceptance of the diversity of client healing needs.

In general, the AR/AO approach is thought to foster recovery through a number of pathways, including empathic validation, empowerment, role modeling, and a corrective experience of inclusion, helping to heal and inspire towards recovery goals and community integration.

### **c) Early and Anticipated Outcomes**

This section describes early and anticipated outcomes at the Toronto Site. Both key informants and focus group participants anticipated that, given the “*expertise*” of supports staff and the “*underlying philosophy*”, long-term project outcomes will be similar across each of three Support Services Teams. These include several domains associated with recovery including: housing stability, quality of life, community functioning health/mental health, health system

service use, and justice system service use. In reflecting on early outcomes, both key informants and focus group participants identified areas that were consistent and other that were inconsistent with their clinical experiences. These include, but are not limited to the following.

#### i) Access to Public Benefits

Access to income supports is regarded a significant barrier for people experiencing homelessness and problems with their mental health. As one key informant noted, most clients “*don’t have any finances*” when they enter the project. A notable early outcome at the Toronto Site is that, once accepted, the majority of clients have been able to immediately access public benefits through the Government of Ontario. These include: Ontario Disability Support Program (ODSP), which provides financial assistance to people with disabilities; and Ontario Works (OW) which offers temporary financial assistance to the unemployed. While contextual factors may delay access for some, as a result of project partnerships with income support services, most clients have been able to gain timely access to public benefits. As one client focus group participant noted,

*“I figure they have a really good relationship with ODSP, seems you get things done quite efficiently with the ODSP workers. Like as if they, they have some professional courtesy amongst them or something because um, I have been doing really well with ODSP since I have been with the program in terms of they haven’t you know hassled me about anything really, like not as of yet you know, but everything is going smooth with them...”*

#### ii) Housing and Housing Stability

Most clients have been housed through the project in a timely manner, reflecting the success of processes and structures that have been put in place for housing. However, for a number of them the housing process was not immediate. This has been attributed in part to problems with staffing models, housing availability in Toronto, and the specificity of some projects participants’ accommodation requests<sup>2</sup>. As one key informant suggested, for these clients, “*the process could take up to three to four months*”.

Housing stability, for those clients who are housed, is regarded as an early success for the Toronto Site. According to one key informant, Toronto “*leads the way*” in housing stability across the five sites. They also remarked that, “[*clients*] *who are housed, are staying housed!*” For these clients, housing is described as a validating experience contributing to positive steps forward.

*“For 5 years I have been homeless or living in shelters so just that whole thing lifted off my shoulders of being in a place and not having to worry about my rent and I can’t even explain how huge that is, I mean I just broke down when I got accepted [into the project], it was, it’s really a huge thing. I am starting school*

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<sup>2</sup> Implementation challenges and barriers are discussed in subsequent sections

*next month and because you know, I have a permanent place to live now... ”*

Maintaining the safety and validation of housing is seen as a motivating factor for clients working towards housing stability. However according to several key informants and focus group participants, as many of these individuals have lived on the street for a number of years, the housing process can be disrupted to their social networks and daily routines. .

*“You lived on the street you knew where to get the food and now you’re like in the West End [Um hmm] like you, you would find somebody in their unit sitting going “What the hell am I doing?” And then they will sabotage themselves ... ”*

As one focus group participant noted, these clients require increased supports and increased visits to help them transition and maintain their housing. Several staff focus group participants also described helping clients with activities such as **learning** to throw out the garbage, do the dishes, or shop for groceries and cook for themselves. As one key informant described,

*“I think then the key component is engaging the client and building a trusting therapeutic relationship because if you don’t have that they are not going to go anywhere. So, if they don’t have somebody that’s going to believe in them and support them and, and encourage them and build that trust that I will be there, and, and it happening, no matter how nice the apartment is right?”*

Both key informants and focus group participants anticipated that housing stability will contribute to a number of additional positive outcomes for clients. As one client focus group participant described,

*“I am just glad I have my own place, well it’s helping me meet new people you know, try to like look forward to, look forward towards something ... rather than just staying at home or going and visiting my parents and not doing anything else in my life, it’s like going to the library, and just pick up a book and start reading a book yourself and it’s a nice and quiet room and that, but in this situation it’s meeting other people, it’s not like being a stranger...”*

### iii) Housing Transfers

While the attainment of housing stability at the Toronto Site has been largely successful to date, a number of clients have had to transfer units. Some of these individuals have been transferred due to eviction, as a result of substance use or other problematic behaviors. Other transfers have occurred because the client’s original housing choice was not a ‘good fit’ for them.

*“It’s the people who in the beginning were just given the list and we’re saying here we have 20 units they jump on it and those are the people we’re seeing a lot of transfers is the people who didn’t have choices, people who wanted to get off the street and grab the first unit they saw.”*

A number of staff focus group participant also described housing transfers as part of natural “learning curve” for clients after a long period of homelessness. Both key informants and staff



focus group participants generally anticipated housing transfers to increase as the project progresses, particularly amongst those individuals who settled on units in order to avoid delays, and those in need of supportive housing. According to one key informant,

*“...we’ll start to see a, a shift as we get more housed... the transfer requests will start to come up, whether it’s because there’s a problem and the person is not successful there or the person wants to move... Yeah, it will certainly keep us moving...”*

#### iv) Crisis, Isolation, and Problematic Behaviours

Both key informants and staff focus group participants reported that problematic behaviours appeared to increase rather than decrease immediately after housing. Several staff members noted that they were increasingly responding to clients in crisis. Some clients were described as having escalated their problematic drug use. Others were described as having increased their contact with non-supportive networks. This phenomenon has been referred to this as *“bringing in the streets”*. Both key informants and focus group participants have attributed these patterns to the loneliness or isolation that accompanies the first months of being housed. As one key informant stated, *“... it’s because they are in a unit and the hustle bustle of life on the street is not there and they are lonely”*.

And while these experiences are anticipated to decrease with time, both key informants and staffs focus group participants have observed a spike in these behaviours during the early months in the project. One key informant reported a peak in problematic behaviours within the first six months of housing, followed by a gradual decrease. Despite these experiences, several key informants warned against overemphasizing such *“setbacks”* over the long term. As one key informant described such experiences as,

*“...it’s more of moving them along the stages of change and where they are as far as pre-contemplation, into contemplation and then some action and then relapse and things like that. So, for me it’s not the outcome that the drug use had decreased but the outcome is that they have had some breakthroughs in their own insight into their use and what they, what they work on. So, whether they are successful or not they, they had periods of success...”*

#### v) Education and Job Development

Finally, a number of key informants and focus group participants described educational development as an early success for a number of clients. As one key informant noted,

*“I remember one case manager came in one day and he was saying that he just settled the person, he moved into the apartment this was very early days and the person turned to, the participant turned to him and said, now I want to go to school and the case manager said oh okay, wonderful um, do you want to talk about that in a couple days like when you’re sort of settled, he said I have been thinking about this for two years while I lived on the street how much I wanted to*

*go back to school . He didn't need to think about it and he is back in school. I mean that is just so wonderful you know?"*

In contrast, it was reported that job development was not a priority at the outset of the project for clients due to the multiple acute issues that they initially presented with. One staff focus group participant suggested that as employment is considered a means to obtaining housing, once housed, clients were less likely to prioritize housing or felt less motivated to pursue employment.

## **Part Two: Implementation Themes**

Key informants and staff focus group participants identified a number of factors that facilitated and inhibited the successful implementation of the At Home/Chez Soi Project in Toronto. Themes related to relationships between project partners, organizational structures, resources, and consumer involvements emerged from the data and are described below.

### **a) Relationships between Project Partners**

The following key relationships were identified as influencing successful implementation and are described in this section: These include relationship between Support Services Teams, the Housing and Support Services teams, the MHCC and the Project and, Research and Supports Services Teams

Collaboration between project partners has evolved through a period of tension, described by one key informant as the usual “*storming*” that occurs between partners “*learning to work together for the first time*”.<sup>3</sup> Tensions during this period were often related to issues of trust, roles and responsibilities, and organizational autonomy. In addition, many of the challenges experienced during the implementation of the At Home/Chez Soi Project were attributed to the lack of time invested in “*team-building*” during the project planning and development phase. As one key informant describes,

*“...often times you talk about partnerships and you talk about making sure your values are aligned, and then you kind of take some time to kind of get to know each other. We didn't have all of that kind of pre-time. So that was just sort of like you, you know, you're the ones doing this and you've got to make it happen. And so we are, and I think that's the beauty of it, that people are able to engage so well, despite any other tensions in the project.”*

Several key informants regarded the collaborative process as a significant achievement between partners with “*established ways of doing things*”.

*“...I am really pleased with how the relationships have evolved. I think there are some tensions in some relationships but despite that, the group as a whole*

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<sup>3</sup> Tensions in the working relationships between project partners were first identified within the Planning and Proposal Development report for the Toronto Site.

*continues to work and move forward...it shows the maturity of the partners at the table.... you're putting together a group of people who didn't come together by choice, they just happened to be the ones who were successful in their applications.... And now we're all working as partners... So, that's the positive...it's the maturity of the clients and the agencies that are at the table that helps us move together, to move forward in getting a lot of this work done..."*

The evolution of a number of key relationships is described below.

### i) Relationships Between Support Teams

One of the early and ongoing successes in implementation at the Toronto Site has been the positive relationships between the three Support Service Teams (ICM, ACT and ER-ICM). Both key informants and staff focus group participants have described these relationships as “supportive” and “understanding”. Further, they are characterized by a high level of cooperation between the team leads. As one key informant described,

*“I just think the 3 team leads enjoy problem solving together and learning from each other. So, that's key because if you don't have that, if you feel that there's power issues or competition or lack of transparency, or are quite closed...but I think all of us, I mean it's been good.”*

While collaboration was evident at the management level, project staff reported only minor contact between Teams. Some key informants and focus group participants also reported early tensions between Support Teams due to competition for housing, and the perception that Teams were being compared to one another on project outcomes. As one key informant described, local governance structures and the development of processes and protocols have helped resolve such tensions. They add that, “...everybody knows we're not competing against each other, I think that's the main thing.” In general, services teams have fostered a collaborative environment that is characterized as learning from each other and learning together.

### ii) Relationships Between Housing and Support Services Teams

The working relationship between the Housing and Support Services Teams is regarded as having evolved significantly from an early tense relationship to a respectful and collaborative one. Early difficulties were perceived to arise largely due to failures in communication that contributed to “instilling lack of trust and faith” between project partners. One key informant attributed these tensions to perceived differences in organizational cultures and service philosophies.

*“I think that from a systems point of view, what I think it is that you've got the housing culture meeting the social services or science culture for want of a better word... there are differences, there's real differences in the way people work and*

*communicate.”*

Another key informant framed this issue as “maintaining landlord relationships” versus “client advocacy”. For example, Housing Connections and the City of Toronto have developed valuable relationships with landlords and other housing bodies that are important to maintain, and are critical to the success of other City-run programs. Support Services Teams have traditionally had to petition such programs for access to resources. One staff focus group participant described the source of these tensions as,

*“...service workers takes an advocacy stance with their client and that’s their role and the landlord takes an advocacy stance for this is my building, this is [housing] needs to maintain it a certain way and [the Project] need certain outcomes from tenancies.”*

These two positions have historically been in opposition. As one key informant described, the protocols and processes that are considered necessary to maintain landlord involvement, are also viewed as cumbersome and incompatible with recovery, particularly if they delay housing for the clients and invade participant privacy and control.

Both key informants and staff focus group participants have identified a number of additional factors that may have contributed to such tensions. These include a lack of clarity around staff roles with respect to housing; transparency on the selection of housing units and the movement of participants along housing waitlists; communication about how discussions on housing choice are facilitated; and, information on the types of follow-up housing support provided to the participants. These issues are felt to have been exacerbated by the pressures of meeting project timelines and having insufficient resources to respond to the rapid pace of participant intake.

The Housing and Support Services Teams also occupy different sites. This physical separation of the teams was identified as a major barrier for timely responses to emergent issues. A number of participants felt they were “missing out” on informal communication opportunities. As one staff focus group participant suggested,

*“I think the real challenge is that the housing folks are not embedded with us, and I think that that’s a real concern, we missed an important opportunity that we didn’t realize we were missing. I think if they had an office here and we were able to walk down the hall and say you know, Sally’s been waiting 3 months and I know you have been trying hard but you know, I really have concerns about her um, a lot of the challenges that we face would disappear pretty quickly.”*

Instead, teams are reliant on traditional methods of communication such as telephone and email that were regarded as “cumbersome” and “unreliable”. Communication through formal project structures was also regarded as lacking the “nimbleness” required to address emergent issues.

Despite ongoing issues, both Housing and Support Services Teams demonstrated an understanding of the challenges faced by one another. Housing staff acknowledged the immense

pressures placed on support staff to handle the rate of intake for new clients by each of the teams, while supporting existing clients and helping them to maintain their housing; and support teams recognized the challenges faced by housing staff in finding units for clients. As one key informant acknowledged,

*“I mean it’s just given the reality of where, the units are available and um, you know, uh, there’s no fault [the Housing Teams’] side it’s just uh, you know, the, the realities of the Toronto market or the difficulties in enrolling landlords.”*

Both key informants and staff focus group participants also added that the working relationship between Housing and Support Services has steadily improved with certain adaptations to both the housing process and staffing model. One key informant noted the relationship between the Housing Team and Support Services Teams *“really got a lot better when they hired on more people...it was drastic difference and quick changes.”* A number of key informants and staff focus group participants felt that mutual understanding and trust have developed out of the shared commitment of partners to the clients and to the values underlying the project.

*“...we need to deal as partners and we need to accept and trust that each other is working in the best interest of the clients and the program... we may disagree, but we’re going to talk about it and work it out because that’s what this whole project is about.”*

In this regard, the relationship-building process has been, as one key informant noted, facilitated by the *“tremendous efforts”* by all project partners to improve the communication processes.

### iii) Relationships between the MHCC and Project

The MHCC’s visibility has been enhanced by the presence of the Site Coordinator, who has a central role in project governance and has facilitated relationships between local project partners, the Toronto Site, and the Commission. This relationship is generally regarded as “positive” and “supportive”. One key informant described the Site Coordinator as an important advocate for the Toronto Site at the national level.

However, some participants perceived that the Site Coordinator’s role has shifted from primarily facilitating implementation to oversight. One key informant described this shift as a product of pressures related to meeting project deadlines. Others have raised concerns that the co-location of the *“funder”* with the Support Services Teams has created a hierarchical structure that has challenged the collaborative model. As one key informant noted,

*“...to have somebody sort of on-site, on the ground watching all the time and questioning and sort of trying to be that facilitator role sometimes becomes frustrating to a process...”*

These views were not shared by all participants with some feeling that this co-location has in fact facilitated valuable opportunities for sharing and problem-solving on both governance and service issues.

A number of key informants and staff focus group participants also reported feeling “*overly critiqued*” by the project and that their concerns about implementation were “*not being heard*” at the National level.

*“I think from the start of this program because it is new and there was never any instructions or protocols ... well we get told when we do something right, but we get told very much when, when we’re doing something they don’t think is right...”*

Several participants noted a lack communication from the MHCC on a number of issues. For example, sustainability planning for the project was regarded pervasive concern for project staff and clients, who largely felt “in the dark” and “uninformed”. Both key informants and staff focus group participants felt a critical need for knowledge dissemination from the MHCC around steps being taken to ensure that clients are not, as one client focus group participant described, “kicked back into the streets”, after the At Home/Chez Soi project is complete. While key informants identified the role of local governance in sustainability planning, specifically the work of the Site Coordinator and LAC, they also expressed the need for greater clarity and direction from the MHCC on this issue.

Despite these concerns, a number of participants positively regarded the MHCC’s leadership and encouragement of local decisions and processes, such as increasing staffing models to alleviate project pressures on Support Services Teams.

#### iv) Between Service Providers and Research

The working relationship between the local Research Team and the Housing and Support Services Teams is described as “*cooperative*” and “*open*”. Participants reported working with research staff on a number of implementation issues, such as participant and staff safety; and, connecting participants to interviews and follow-ups. Despite the positive relationship, a number of staff members reported feeling disconnected from research activities. As one staff focus group participant described, “*...we’re not really familiar with what the different pieces are and when they need to be done.*”

This “*unfamiliarity*” was felt by some to lead to a hesitance amongst staff to take part in research activities, including the implementation evaluation. Greater education was regarded as necessary in order to better align research activities with service delivery. As one key informant described,

*“[We] are not researchers right ... so maybe if we had more time I would suggest that maybe a little bit more education of the service providers in terms of how the research is going to be conducted, what each step means...”*

## b) Structures

The following key governance structures were identified as influencing successful implementation and are described in this section: These include Site Operations Team (SOT), the Local Advisory Committee (LAC), and various working groups and ‘ad hoc’ committees.

A formal governance structure has been established at the Toronto Site, featuring the SOT, LAC, and five working committees: Referrals, Housing, Ethnoracial ICM Service Model, Research, and Services. The composition of this governance structure is a source of contention between program partners that has persisted from the planning and development phase of the project. While some structures are regarded as having been effective in supporting implementation, others are described as requiring further development.

The SOT is primarily responsible for local governance, and includes representatives from each of the project partners: the MHCC, Housing Connections and The City of Toronto, the Centre for Research on Inner City Health (CRICH), Toronto North Support Services, COTA Health, Across Boundaries, as well as the Consumer Caucus. A number of participants expressed concerns about the large size of the SOT affecting its ability to efficiently address implementation issues. However, others thought that the SOT has been effective in addressing operational issues at the Toronto Site. One of its key activities has been the development of a memorandum of understanding (MOU) for the Toronto Site, including protocols to clarify process, roles and responsibilities around key implementation issues. Despite early delays, the development project MOU is regarded as a “*major evolutionary process*” for the Toronto Site.

*“I think the development of the MOU and the protocols helped bring the team together in hammering out really specific implementation details and that helped in evolution, it helped a collaboration, and it also helped the teams realize how much they intersected, how much interdependence there was...”*

At the service level, these protocols have helped to clarify roles and responsibilities between project partners and to address certain operational assumptions. These include, for example, decision-making authority and processes among project partners. Protocols have been developed on a range of operational issues such as discharging participants from the project, processes for housing move-in and transfers, and ensuring worker and participant safety amongst others.

The LAC was formed as a mechanism to promote community and policy maker / funder involvement in the project. While, a number of key informants described “*growing pains*” in defining the composition and function of the LAC, it is largely regarded as playing a key role, along with the SOT, on sustainability planning.

Some regard the number of work groups and project committees as inefficient, time consuming, and having a “*silo-ing*” effect. Others see them as important structures for sharing knowledge and addressing operational issues. As one key informant described,

*“I think just having those, sort of overarching groups or teams or committees has*

*been beneficial because it's allowed all of us to be on the same page of this project right? So, we're not kind of work in silos, we're really working together with a focused goal in terms of what we need to get to and also when we are experiencing challenges we are able to share within. Um, then there is also specific committees as you know, there's the ethnoracial work group, and the services work group and then um, the clinical team so all of these structures that have been put into place I think are really useful because it allows a, a space for issues to be discussed and addressed..."*

Several key informants described successful work groups and committees as having a clear purpose, process, participation and leadership. In this regard, a number of key informants identified the housing work group as a "clear success". As one key informant noted, *"I think they're very clear about what issues should come to that body and, and how, how that gets processed...I think they have done a great job..."*

The housing work group has been able to bring a number of community partners to the table to provide "an umbrella of supports" for the Housing Team. Participation in this group includes representatives from the ODSP and OW who have played an important role in expediting participants' access to government income supports. According to one client focus group participant, *"we're getting people into ODSP at an amazing rate because we have senior reps from ODSP and OW sitting on the housing working group."*

Participants also identified a number of "ad hoc" committees that have played an important role during the implementation process to date. These committees were created to respond to emergent issues such as housing delays, complex clinical issues and to address tensions between teams. For example, several key informants described the Clinical Support Team as having had a positive impact on the project. This team is comprised of the three service leads and one of the project principal investigators, who is also the director of the Inner City Health Associates (ICHA, a group of physicians working with homeless project participants in Toronto). The Clinical Support Team has played an important role in addressing issues related to safety, clinical problem solving and the potential discharge of clients.

## **c) Resources**

A number of resources that have influenced successful implementation were identified and are described in this section: These include local partnerships, National Training, and the Project Office.

### **i) Local Partnerships**

Local partnerships and capacity have been instrumental to the successful implementation of the At Home/Chez Soi Project in Toronto to date. Both key informants and staff focus group participants acknowledged the valuable contributions of each of the project partners. As one key informant described, *"many of the resources that have been tapped into [by the At Home/Chez Soi Project], have their origins locally"*. For example, Housing Connections' partnerships with



landlord associations and the Ontario Council of Alternative Businesses (OCAB) are regarded as invaluable to the housing process.

Similarly, the Support Services Teams are seen to have significantly benefited from the supports provided by the Inner City Health Associates, who have facilitated access to on-site primary care physicians and psychiatrists for both the ACT and the two ICM teams. These diverse partnerships are regarded as integral to providing the comprehensive supports to clients, as one key informant described,

*“I would say that... there are partners in the community [who], in an operational way are very helpful around, providing programs that participants are engaged in... because no one partner provides everything. So, that linkage to the service system that’s there, that community supports that exist, the mental health system that exists all will be important depending on the needs of the individual.”*

## ii) National Training

From the National level, the MHCC is seen as providing an umbrella of supports and services for the local teams. The MHCC has provided several training opportunities and has facilitated the development of communities of practice across housing, service, and research teams nationally. As one key informant described,

*“... we got lots of training, lots of money, nobody has that kind of, the opportunities that they’ve had around ability to go to conferences, ability to learn together, ability to attempt course, they had a whole month of orientation nobody has had.”*

These resources have provided a “good foundation” and “excellent jump off” for Support Services Teams that are characterized as “well-resourced” compared to other programs. However, some participants have expressed concerns that these opportunities are “not necessarily seen as an ongoing resource”.

## iii) Project Office

Finally, the Project Office has been described as both a barrier and facilitator of the implementation of the At Home/Chez Soi Project. The office, which is shared by both the Site Coordinator and the ICM and ACT team, has created opportunities for informal learning and facilitated relationship-building. As one key informant described,

*“I think having positive relationships with our partners is critical to the [the Project’s] success and I think sharing space has been part of the success...sharing space has been really helpful because then things don’t fester, you have these informal conversations, you understand where people, what people are doing, you understand people’s pressures um, so that’s been really helpful but not everybody shares spaces.”*

The project office has also allowed teams to share valuable administrative resources such as full time receptionists, and provides the Toronto Site governance structures with a centralized meeting space. However, some key informants and focus group participants felt that the shared office limited the ability of the ICM and ACT teams to fully identify with, and have ownership over the space.

The Project Office's central location is regarded as decreasing accessibility for clients living outside of Downtown Toronto. Some key informants have raised concerns that its location has also prevented the ICM team from utilizing other programming opportunities available at their agency's main office location due to space constraints. As one key informant described, "*...the disadvantage [of the project office] is that we're disconnected from all the other stuff that goes on within our organization.*"

In contrast, the ER-ICM team has benefited tremendously from the being housed at their home office; apart from the Project Office and the other support teams. The team has been able to access the various drop in services and informal supports available to them at Across Boundaries. As one key informant described,

*"...at the time I thought that it was a shame that they didn't join us here but now I, I understand, I understand why they, really wanted to be [at their own office] ... for their program, their project has to be an extension of what they had there."*

This space has been described an important part of the ER-ICM model, and key facilitator of successful implementation.

#### **d) Consumer Involvement**

The Consumer Caucus' role in the implementation process is a unique feature of the Toronto Site. The Caucus is comprised of twenty-two persons with lived experience (PWLE) with mental health problems and/or homelessness who participate in local governance and service delivery structures. The Caucus is supported by the OCAB, and meets regularly to review project activities and to discuss issues of concern for Caucus members regarding service delivery.

Many key informants and focus group participants regard the Consumer Caucus as having had an "overwhelmingly positive impact" on the implementation of the At Home/ Chez Soi Project,

*"In an environment like this for this client group, that's fantastic you know, the biggest partner of all is the Caucus and they are very important...[they are]our consciences, and they are our in-house experts, and that part has just been very helpful..."*

Representatives from the Caucus are included on the Site Operations Team (SOT) and the Local Advisory Committee (LAC), as well as the various project work groups, where they have been described as having a "*tangible effect*" on both housing and service delivery by providing guidance in the development of protocols in these areas. As one staff focus group participant described,

*“There have been several examples where the Caucus’ input in uh, particularly the housing working group...one in particular that comes to mind for me is the, the emergency furniture um, where you know, we looked at do we wait for furniture to be delivered to a unit before getting somebody into a unit or is there a way to just get you know, get some uh, blow up mattresses in there and some, some linens in there and have somebody in a unit and you know, the original thinking was now we can’t really get somebody a new unit if they don’t have the furniture but those, the, the Caucus members have said what are you talking about, get a roof over our heads, we’ll sleep on a blow up mattress for a few days right...that kind of real meaningful input has, has impacted profoundly the direction that we’ve taken.”*

Caucus representation on the various work groups for the project is seen to have strengthened the Toronto Site’s ability to “*advocate and petition for additional resources for participants*”. As one key informant noted,

*“I just found...a sense of resourcefulness that was brought to the table by the Caucus members like we don’t have, the people around that table that...don’t necessarily have lived experience either with mental health problems or homelessness and so we can talk up here in the clouds but then all of a sudden brought right, they bring you right back down ... it’s useful [the] real experience they brought to developing the protocols and making changes from the meetings that I have been at...”*

While most key informants indicated that Caucus members provided a valuable and unified voice for persons with lived experience in the project, some cautioned against “homogenizing” the diversity of these experiences. Further, the Caucus’ input was also regarded as “time consuming” and “challenging” by some. This has been attributed in part to the amount of “processing” that is required to ensure their meaningful involvement. One key informant described the process as unrealistic given “the pressure and time constraints [created by] the project”. Caucus members who participated in the focus groups also expressed concern about the risk of “tokenistic” involvement without sufficient time during meetings to “feel heard”. And while they were proud of their contributions, they acknowledged the difficulties experienced in the process to date.

Despite these concerns, the Caucus is overwhelmingly regarded as a key liaison between the project and the community of persons with lived experience.

*“One of the outcomes that I hope for is that there will be a way for the work of the Caucus to be sustained um, not just on, on this particular project but after...in a way where they can really contribute to social issues.”*

## Part Three: Developmental Themes

This section describes contextual factors influencing the implementation of the At Home/Chez Soi Project in Toronto, as well as adaptations and innovations that occurred in response to these factors.

### a) Housing Choice, Availability and Affordability in Toronto

Appropriate rental inventory in Toronto is in short supply due to the scarcity of affordable housing units, particularly in Downtown Toronto. For clients with limited incomes, there are significant wait times for those units that are available. Further, vacancy rates in Downtown Toronto are regarded as particularly low.

Established cycles in the rental market are seen to influence both housing cost and availability. These factors contour the types of decisions clients are able to make about their accommodations. As one staff focus group participant noted,

*“Housing, we find, falls into the regular housing cycles that happen in a market rent environment. August, September are very difficult to secure housing [due to] students [and other] people moving... it’s the time that landlords can get the premium price and have their selection on tenants. So, we can’t move as much through that time period...”*

Staffs also noted a lack of supportive housing options in Toronto, and long waitlists for those that do exist. This has been a particular concern for clients who prefer supportive housing but who as a result are “forced to live independently”. Several participants anticipated that this ‘gap’ would have significant consequences for these participants. As one key informant described,

*“We have clients raring to get out of shelter, off the streets and there is just nowhere for them to go and, and so there’s the pressure from the Project to house as quickly as possible but it’s just not, maybe not appropriate, therapeutic, not going along with client choice or whatever, there [are] so many reasons why it’s not going to work out.”*

Another key factor influencing housing availability has been the willingness of landlords to provide units to clients. According to one key informant, “a small number of landlords and corporations own the majority of units across the city.” They add that, larger landlords typically have shorter lengths of tenancy and higher rates of vacancy, and are therefore more likely to provide units for clients.

A challenge for the Housing Team was working with smaller landlords, who own the majority of rental units available in Downtown Toronto. According to staff focus group participants, these landlords typically had longer lengths of tenancy and lower vacancy rates. Thus, more time and resources were required to identify willing landlords with vacancies. Some

staff also felt that smaller landlords were hesitant to work with a “*large project*”, due to “*all of the paperwork that that it entails*”. Others felt that smaller landlords were also more reluctant to provide units to clients.

Several adaptations have occurred in response to the competitive housing landscape in Toronto. These changes were necessary to facilitate housing choice within the context of a time-limited project.

Clients receive a package of resources as part of the Toronto Site’s housing model that are regarded as unprecedented and essential to improving cooperation from landlords. In addition to the rent supplement, the model includes a budget allowance for furnishings and move-in costs (\$1500 per participant); last months’ rent and a vacancy loss fund; insurance to cover damages; and, a fund for temporary accommodations. These features are regarded as having been critical to promoting buy-in to the Project, particularly amongst smaller landlords, and reducing obstacles typically faced by low-income tenants.

The original approach to housing was based on an “inventory of units” that was developed and maintained by the Housing Team. The approach was believed to be the optimal means of facilitating timely access to rental units for participants. As one key informant described, the inventory approach “*reflected the realities*” of the housing situation in Toronto, and was regarded as “*unprecedented resource*” with which to “do Housing First”.

The original housing inventory consisted of units that were predominantly located in the West-End of Toronto, building on existing partnerships between the City, Housing Connections and various housing bodies. This approach was regarded as “*successful for some, but not for others.*” As one key informant described, the inventory approach tended to be more effective for housing participants of the ER-ICM, due in part to the agency being located in the West End.

Challenges emerged when attempting to house participants who preferred to live in more central locations that were not available through the housing inventory. As one key informant described,

*“...the original housing stock that we had [was] in outlying areas and there were clients who wanted those units on all the teams, but a lot of clients said “I don’t like any of those areas” and then we had the problem of trying to find affordable units in the areas they wanted.”*

For these clients, the housing process was delayed, sometimes significantly, creating challenges for support staff. As one staff focused group participant noted,

*“...if a client decides to choose a certain area and, and it’s not on the list and they’re sitting you know, for, for 3 months you can imagine the type of frustration they are going through you know, it also comes back to the worker where you know, the client now is so frustrated.”*

A number of key informants highlighted the process of collaboration that occurred between project partners to improve the housing choices offered to clients.

*“We moved from, ‘well if not the inventory, then what?’ in order to be fast because we do have to be quick and it isn’t just about meeting the project benchmarks... it’s really the right thing to do on a humanitarian level when we’re engaged with people waiting and waiting, some still choosing to stay on the street while they wait because they are afraid of shelters. So I think it was just through this transition of thinking “how do we do this...?”*

In order to accommodate these individuals, the Project focused on identifying units that were more centrally located. In order to facilitate this process, the Housing Services Team was expanded and processes were put in place to increase the Project’s flexibility around the housing options available to clients. One key informant describes this as a “shift from inventory and units to the participants”. A number of key informants and focus group participants regarded the hiring of additional housing staff to facilitate housing choice as an important adaptation for the project. As one staff focus group participant described,

*“Because at the end of the day it isn’t about the inventory it’s about... the project ... and it’s about the participant. So, it worked part of the time and some of the time it just was not the answer so then we had to bring in the resources and [Um hmm] bringing in additional staff... did help there but we still have a distance to go and that may require more staff.”*

The Project adopted a more targeted approach to housing that was coined the “bottom –up” approach. Rather than providing participants with a list of options, support staff would work with the client to identify vacancies in neighborhoods that the clients preferred.

The overall approach to procuring housing for clients now consists of three general processes: 1) approaching interested landlords about future vacancies, 2) maintaining the housing inventory, and 3) facilitating the “bottom-up” approach. As one key informant describes, “it was a very important shift to happen which helped bring everybody together a little more... on to the same page.”

## **b) Service Density and Participant Recruitment**

The density of health and social support services available in Toronto for people who are homeless is regarded as high compared to other sites. The Toronto Site recruits participants through referrals from agencies and organizations that are in contact with people who have experienced homelessness and problems with their mental health. This approach is grounded in an appreciation for the established connections that most have to Toronto’s “rich” networks of support services. As one key informant described,

*“...my understanding to date is we have not run into anybody on the referrals who wasn't already connected to a service provider, so we use the strength of that relationship to support the individual and to also give them more um, give the researchers more insight and to how to best place the individual and best work with them.”*

A number of key informants regarded Toronto's approach to participant enrollment as an important adaptation of the project to the local context. It was developed by the referrals working group, drawing on broad community representation in order to develop a recruitment strategy that was respectful to the needs of the individuals and the community. As one key informant noted, this approach also ensured support would be available to both service recipients and treatment as usual study participants. According to another key informant,

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

This is regarded as “a very powerful approach”, that recognizes the importance of maintaining and drawing upon the participants existing relationships in order to help support them. As one key informant noted,

*“... The last thing we wanted to do was to create a time-limited artificial process of going and getting people off the streets that could have interrupted the other service-rich environments we have.*

This approach is also regarded as a way of conducting research that does not exploit the participant,

*“... people on the street really struggle with the number of people who are dropping by talking to them asking for their stories, offering a meal, offering this that or the other, and we learnt very early on that they were left confused, they felt exploited and they couldn't understand why they had to keep repeating their story and no one would help them. And so we were able to create a model here that didn't put us back in the dark ages of treating people that way.”*

Several participants also described this approach as enhancing the recruitment of ethnoracial participants, particularly for the project's Third Intervention Arm. During the process of protocol development, it was recognized that homeless individuals from ethnoracial groups are often situated “off the street”. As one key informant suggested,

*“...folks on the street are not very diverse because as you probably know different cultures allow or don't allow their, their relatives to be on the street.”*

Another key informant noted that the shelter population in Toronto is largely comprised

of white and aboriginal males. Thus a recruitment model that focuses on referrals from community agencies, such as those explicitly serving ethnoracial participants, is viewed as a means of increasing the project's "reach" into these under-represented communities. Further, key informants note that this approach to referral and enrollment has provided the Project with greater "community buy-in" and may enhance long-term project sustainability.

### **c) Delayed Participant Recruitment**

Delays were experienced in the initial recruitment of participants in Toronto to the At Home Chez/Soi project. As one key informant noted, during this period staff were operating with small caseloads. This period is characterized by increased utilization of training opportunities, and Service Staff having significant time to dedicate to participant engagement. However, as one key informant noted,

*"[Delays in enrolment] afforded [the Support Teams] time to do a great deal of staff training and staff development which uh, is never lost but there was a certain level of frustration there as they were waiting to put all their wonderful skills to good use."*

Several factors were seen to have contributed to early delays in recruitment. One key informant suggested that delays were in part due to the care that was taken to arrive at a recruitment process that was acceptable to all stakeholders. Others have pointed to delays in the recruitment and training of research staff as contributing to early recruitment issues. These challenges have required several adaptations, included increasing research staff and greater outreach by project partners.

Subsequently the Project experienced a period of rapid recruitment and intake in order to meet project timelines. Responding to the rapid rate of enrollment was described as a challenge for both Housing and Support Services staff.

*"...because our enrolments were delayed so long in Toronto and didn't really start kicking off till February that meant that the number of referrals that an agency received per month was much higher than you would ever see in a program, and that created serious problems [for the Support Services Teams]."*

One key informant noted that as result of the randomization of project participants, Support Services Teams could not anticipate the particular rate of intake from week to week. Not being able to control the process was regarded as a major adaptation for Support Services Teams.

*"...intake occurs through the Research Team and [Support Team] don't know the individual so they get a phone call, they get a fax and they're off and running to meet the person and they don't have a choice as to whether they accept this person or not so that's very different from the normal way of working in an organization"*



Overall the recruitment phase was characterized as limiting the ability of Support Services Teams to work with clients, and contributing to high levels of stress amongst support staff.

#### **d) Serving Participants with High Levels of Need**

The complexity of clients' needs has presented a number of challenges for each of the Support Services Teams. A number of key informants and focus group participants characterized clients as "*often those who have not been successful elsewhere*". This is seen to reflect gaps that exist in the current system of support services within Toronto, as well as the level of need that is present within the homeless population. As one key informant noted,

*"I think for many, many years we have not understood the lives of the clients in the system who, who really don't do well, we, we don't serve them well... so they um, they fall through the cracks everywhere, they're very hard to serve in the sense that we don't know what helps them."*

Support staff regarded failures to support these clients as a system-level failure and not a reflection of the Project or support staff expertise.

Concerns were also raised that Support Services Teams were receiving participants with levels of need that were incorrectly matched with the ACT or ICM models. This led a number of key informants and staff focus group participants to question whether their particular service models were appropriate to meet the needs of these participants. For example, one key informant felt that despite the level of resources allocated to the project, the ICM model does not have the expertise necessary to support participants with particularly high levels of need.

*"So, we have a, a whole bunch of folks like that I think on this program who have through no fault of their own have ended up with really poor, poor coping skills um, a lot of anger issues, a lot of uh, challenges taking responsibility for their decisions, uh, a lot of drug abuse, a lot of you know, substance use in general and so they, they're here with us and we're doing the best we can but it has many challenges and, and, and staff are barely able to manage many of these folks I mean it's we, we don't have the skills, we don't have the expertise um, to manage this client group very well."*

One of the important and innovative adaptations of the At Home/Chez Soi Project has been the development of Clinical Support Team, comprised of the three service leads and one of the project principal investigators, who is also the director of the Inner City Health Associates (ICHA, a group of physicians working with homeless individuals in Toronto). The Clinical Support Team was developed to assist support staff in problem solving around complex issues presented by clients. These include issues related to safety and the potential discharge of clients. In an effort to provide psychiatric expertise that is not traditionally incorporated into the ICM model, both ICM teams have been provided with additional training and access a psychiatrist who also attend some of the team meetings

## e) Support Services Caseloads

Although many regarded the Support Services Teams as well-resourced, concerns have arisen that staffing ratios have been insufficient to “*reasonably support clients*”. The ACT model is based on a 1:10 ratio of staff to clients, and the ICM model is based on 1:20 ratio. In particular, key informants and focus group participants expressed concerns that these standards were not based on “caseloads” that reflected the complexity and level of need amongst clients. This was a particular concern for the ICM model. One key informant reported that other programs working with similar populations operated with caseloads between 8 and 12 participants. They added that in typical community support case management programs with caseloads of 16 to 18 clients, participants tended to be more stable or, were housed.

The caseload size was a major concern for each of the three Support Services Teams. One staff focus group participant stated that,

*“...larger caseloads mean that you’re responding more to crisis as opposed to working on recovery goals and building relationships”.*

They add that the prospect of operating under a full caseload was “*unrealistic*”. One staff focus group participant characterized the size of caseloads as “*negligent*”. Furthermore, the prospect of re-housing clients with a full caseload was described as a “*daunting task*”. As one staff focus group participant described,

*“I honestly think that the caseload size is the most significant challenge for us and until we address that we won’t be providing anything significantly different than we are now um, you know.”*

Both key informants and staff focus group participants have identified a number of factors that have limited the time available for staff to work with clients. For example, all clients are provided with access to 12 hours of daily support, with community crisis supports services providing after hours support. The ACT model also provides supports services on weekends. Several key informants and focus group participants pointed out that in order to ensure these levels of support, not all staff can be available daily within a forty-hour work week. Thus, the full ACT Team is only available one day a week, and case managers in the ICM team are only available four and half days a week to work with clients.

Key informants and focus group participants also regarded weekly contact with all clients as unrealistic, particularly given the number of clients who are experiencing crisis. One key informant added that some clients also require space to “*settle in*”. Both key informants and staff focus group participants described the need for flexibility to “*triage*” participants based on their level of need. However, they also reported feeling pressured by the project in this area.

Balancing both the housing and service components of the project has been difficult for staff. They feel that they do not have enough time to engage clients in ways that reflect their expertise.

*“Right now what the workers are expected to do is housing, case management, and intake that’s 3 different jobs in, in a shelter um, or many other programs um, and we’re, we’re doing all of it, that’s not to say I do believe that a continuum of care and being able to, to sort of engage with a client while they are on the street and then help them find housing, does strengthen your relationship with them. Like I do believe that but there’s got to be pieces that have to be picked up by someone else.”*

These factors are also seen to be compounded by project catchment areas. Clients are located across the city and staff report that they are spending significant amounts of time on travel. According to one staff focus group participant, time spent traveling accounts for a major proportion of work hours.

*“.....today my, my visit started in Broadview and then ended up in Etobicoke, that’s quite a distance you know, and we try as much as possible to kind of you know, cluster them where you do visits within the same area but it’s not always possible depending on what’s going on.”*

Both key informants and staff focus group participants have raised concerns about “burnout” amongst project staff. This has largely been attributed to staff dedication to the clients despite the myriad of stressors that they have encountered through the implementation process. One staff focus group participant described this as “compassionate fatigue”, characterized by staff dedicating their “time-off” to completing project tasks, or responding to client’s calls after hours.

However, the level of stress and frustration experienced by some staff has resulted in a number of staff having to take ‘sick leaves’, while others have left their positions. As one key informant warned,

*“I think each and every one of us took this position um, excited about the position... I will speak for myself and I think there are a few people nodding in the room saying that when they entered we were excited about this. Personally I was quite happy in the position that I was in before but thought that this was an opportunity um, to really help make a difference um, in a way that we have never done before....but, I think that’s, I think it’s important to know that worker’s morale or sense of morale, and sense of uh, not power, but sense of uh, uh, like I don’t want to say empowerment because you can’t really empower anyone, but um, just that feeling of job satisfaction has steadily declined um, for many of us um, because of everything we are facing. It gets tiring um, it get’s exhausting fighting the same battles very, very little progress. Um, our clients are not the problem um; in fact I love the clients.”*

Several staff focus group participants warned that future staff turnover is likely, and highlighted the need for a greater emphasis on staff needs; creating opportunities for “worker self-care”, time and opportunities for staff to debrief on their concerns; and timely organizational response to staffing shortages.

Both key informants and staff focus group participants noted that processes have been initiated to address staff concerns. In order to reduce caseloads, the project has approved additional staff for each of the Support Services Teams. A temporary moratorium has also been placed on intake for teams feeling “*over-whelmed*”.

## **f) Strong Leadership**

Both key informants and focus group participants highlighted the strong leadership provided by each of the team leads as a key facilitator of successful implementation. These individuals are generally regarded as central to staff recruitment and retention. Some focus group participants reported that their team lead was the “principal reason” that they joined the At Home/Chez Soi Project. While staff turnover has occurred amongst all teams, a staff member who was leaving their position described,

*“One of the reasons I am sad to leave this program is not the program itself but the manager um, I have never had a, such an amazing manager who, who really understand the works as she’s done it.”*

They expressed concerns that teams lead were also under pressure to balance project organizational activities, while providing supervision for project staff.

## **g) Adapting to Changes to the Policy Landscape**

On June 15, 2010, the Government of Ontario amended its Occupational Health and Safety Act (Bill 168) requiring employers to develop written policies around worker safety and harassment. This legislation has required that service providers adjust their operating procedures, and has raised a number of questions for staff.

While this meant that greater project resources were diverted to safety issues, this policy change has also resulted in stricter rules around staff reporting procedures; requiring staff spend greater amounts of time on documentation. For ICM staff in particular, Bill 168 limited their ability to operate out of both the Project Office and the Toronto North office, thereby increasing their travel time to see certain participants. The cumulative effect of these seemingly minor operational changes is regarded as a significant constraint on staff time to work with participants. However, one key informant added that staffs have also become more aware of safety issues.

*“The clients are the same as they have always been, they are no more dangerous than they ever been but there is a, a different consciousness in the part of workers now about needing to be safe.”*

However, protocols and processes have been developed at the Project governance level to address the safety of service staff and to streamline reporting procedures.

## **h) Ethnoracially Diverse Populations.**

Key informants and focus group participants describe challenges meeting the cultural and linguistic requirements of diverse clients. Despite their experience and capacity, each of the Support Services Teams have had to adapt: by hiring peer workers; seeking out staff who reflect the diversity of participants; or utilizing linguistic and other translational services. For example, the ER-ICM team has typically worked with the African-Caribbean and South Asian community in Toronto, and through the Project, is now also assisting Chinese and Korean participants. As one key informant described,

*“We have clients that speak different languages...in my team I don’t have a Korean-speaking member, so we have a few clients now... we have to tap into the translation services outside of what we already have. So, it’s a little extra, a little extra has kind of gone onto this stuff.”*

The ICM team has taken the lead in working with aboriginal participants, who are over-represented amongst the homeless population in Toronto. One key informant described the unique challenges hiring and training culturally competent staff as,

*“...we are not an “aboriginal organization” and that... some organizations would hold that us against us. We’ve tried very hard to hire staff, aboriginal staffs who feel comfortable working in our organization... and many do... but it’s... it’s not always possible to find somebody who has the right knowledge and skills and the cultural background.”*

Despite these challenges, the Support Services Teams have been able to successfully recruit diverse ethnoracial staff to assist in appropriately addressing participants’ needs and to enhance “buy-in” from Toronto’s many ethnoracial communities. This process has been enhanced by the creation of the Third Intervention Arm that has an explicit anti-racist/anti-oppression mandate in providing care to ethnoracial participants. As one key informant noted,

*“...there is good case management practices that are available out, but unfortunately we’re talking about clients from racialized communities specifically, you know, agencies have policies around diversity and equity and what not and it’s great, but when it comes down to the actual working with the clients from that particular perspective um, we have experienced that it’s not necessarily the same as what [the ER-ICM does]..”*

## IV) Discussion and Lessons Learned

Key informants and focus group participants identified a number of contextual factors that have been barriers and facilitators for the implementation process at the Toronto Site. These factors have determined the successful implementation of the Project to date. The following section highlights elements of implementation that have been working well and those that have not. They are organized as elements relating to the Project level and those relating to the Service Delivery level.

This data reflects the views of the key stakeholders, including the various project partners, housing and service staff, and clients on implementation processes that have occurred between October 2009 to January 2011 in the At Home/Chez Soi Project.

### a. Successful Elements of Implementation

#### i. Project Level

- **Recruitment:** The approach to recruitment of homeless people with mental health problems maintained existing service relationships for clients, within the context of a rich service environment, thereby improving community “buy-in” and enhancing supports available to clients.
- **Housing Model:** The housing model facilitated “choice” and maximized clients’ post-rent income, such that no more than thirty percent was used for rent. Housing supports included a \$600 dollar rent supplement, furnishing, and contingencies to facilitate the ability of clients to transfer housing if necessary.
- **Partnerships:** Project partners contributed valuable experience, expertise, and service relationships to the Project. Partnerships also increased the Project’s “reach” into the networks of supports and services for people who have experienced homeless and mental health problems, enhanced access to housing units and, expedited access to government income supports for clients.
- **Attention to racialized groups:** Racialized clients have been successfully engaged through the Ethnoracial Intensive Case Management model that utilizes an Anti-Racist/Anti-Oppression framework.
- **Governance:** Project governance structures have facilitated communication between project partners, provide mechanisms for project partners to define roles and responsibilities to collaborate on emergent issues and, created avenues for conflict resolution and partnership building.
- **Consumer Involvement:** The PWLE Consumer Caucus has grounded the Project in the lived experience of clients, enhanced project capacity to advocate for resources, and has led to adaptations in housing and support services delivery.

ii. Service Delivery Level

- Range of Supports: Clients positively regarded the quality and types of support services they have received, and praised the dedication and work done by the Support Services staff.
- ER-ICM: Clients in the Third Intervention Arm identified the ER-ICM office as a welcoming environment where they could take advantage of a range of drop in services, and have a place to interact with others.
- Recovery Orientation: Support Services staffs have assisted clients on a range of recovery goals, including education and vocational development, building social networks and community integration, and connecting with families.
- Multidisciplinary team: Clinical Support Team as well as on-site psychiatrist and primary care have enhanced Support Team's response to individuals with complex health needs.
- Choice: The majority of clients have been successfully housed and have received accommodations that are consistent with their choices. The "bottom-up" approach has enhanced housing choices for clients, facilitated by additional staffing on the Housing Team, and the work of Support Services Staff assist client in articulating their accommodations needs.
- Flexibility as a determinant of housing success: Housing has been most successful for clients who are able to live in independent housing units, who do not have very specific housing requests, and those who are willing to accept units in areas outside of downtown Toronto.

**b. Unsuccessful Elements of Implementation:**

i. Project Level

- Communication between partners: Lack of early opportunities for "team-building" has contributed to the slow development of the relationship between Housing and Support Services Teams. Steps are being taken to improve communication, cooperation, and trust between the project partners.
- Housing rates: Focus on immediate housing has contributed to tensions between project partners working to accommodate housing choice in timely manner.
- Time needed for governance: Participation in various project governance structures has been time consuming. There is need for greater efficiency in meetings, and clarification of structure, roles, and responsibilities in some work groups.

- Research Clarity and Communication: Project staff concerned about lack of clarity regarding research and expectation, which has contributed to reluctance to participate in research activities.

ii. Service Delivery Level

- Failing to satisfy housing choice: Housing choice was limited for some early clients and those requiring supportive housing, resulting in increased housing transfer request amongst this group. Delays in housing for some clients have had a negative impact on their relationship with Support Services staff that “feels caught in the middle”.
- Overworked staff: Support Services staff reported feeling burnout due to pressures to meet project timelines; balancing multiple roles; coping with high intake rates and caseloads; project catchment area; and, working with clients with complex needs and those in crisis. Additional Support Staff have been added to each of the Teams in order to reduce caseloads and support teams have been offered "time-off" from new referrals.
- Staff not feeling heard: Support staff voice the need for greater opportunities to debrief on challenges and negative experiences and time for “self-care”, contributing to some staff feeling overwhelmed and disempowered.
- Lack of drop-in services: Not enough opportunities for programming and drop in services for both ACT and one of the ICM teams were attributed to workload and limitations of project office.

A number of important themes have emerged in Implementation Evaluation findings. For example, communication has played a central role in the relationship building process at the Toronto Site, and was seen to contour many of the challenges that were identified throughout implementation. These challenges have persisted from the planning and proposal development phase of the project, and were evident in areas of project governance as well as service delivery. Several of these tensions may be attributed to the differing paradigms or perspective from which project partners approached the same goals—Critical questions have included: How do we understand choice, and how is “Housing First” best achieved? While formal structures have been critical in bringing partners together, resolutions have largely occurred through informal processes, driven by shared overwhelming support for the clients, the “Housing First” model and, the spirit informing the implantation process: collaboration, dedication, and goodwill.

While the types of supports and services built around the “Housing First” model were regarded as innovative and well-resourced, it is evident that the combination of factors has produced a challenging environment for project staff to operate within. These factors include: delayed start in the implementation process; large and unbalanced caseloads; housing and Support Services functions; the complex needs of clients; and, the time-limited recruitment phase of the At Home/Chez Project.



Although clients have been unanimous in their praise for the both the Project and the resources that have been afforded to them, staff “burnout” and turnover may have a significant impact on their recoveries, particularly as the working relationship is presumed to be an important catalyst in the recovery process. Several steps have been taken to improve the service environment for staff, and it will be important to monitor their impact in subsequent evaluations.

Finally, a despite these challenges a recurrent message from both key informants and focus group participants has been the importance of not losing sight of the numerous project successes to date. These include the tremendous collaboration that has taken place at the Toronto Site, the numbers participants who have been successfully housed, and who are working on their recovery goals.

*“They got me uh, they had, they uh, they got an apartment, they helped me get an apartment for sure. It was fantastic uh, it was fantastic I had a, I had um, I was involved with a housing program before and you had no choice in the matter and um, I, I mean it was great because I was able to find an apartment that was a great fit for me in terms of um, location and uh, and the size of it, being a one bedroom and, and being central, it was really great for me. Um, it’s the best apartment I’ve ever had, it was my favourite apartment that I have ever had and um, I couldn’t have done that without um, this study at all. I really feel fortunate and blessed by this study just to get that, to get that kind of help is really significant and it’s uh, fantastic.”*

## **V) Conclusion**

Implementation Evaluation of the “At Home/Chez Soi” project has focused on key themes including the critical ingredients of the “Housing” first model, as well as important aspects of program theory and program mechanisms of change. The research also highlights the unique features of the Anti-racism/Anti-oppression model that informs the Third Arm intervention. The Implementation Evaluation has identified a number of challenges, and highlighted a number of successes that have occurred during this process. This documentation will inform project adaptations in order to more effectively deliver services to Toronto’s diverse population experiencing homelessness and mental health problems. The Implementation Evaluation has also highlighted important contextual factors that should be considered in subsequent research, including evaluations of the project’s outcomes. The experiences of the Toronto Site may also offer important lessons for implementation at other sites of the At Home/Chez Soi project, as well as similar research and project development in other jurisdictions.

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## **Appendix A: Project Context**

### **a) Site Description**

There is a large pool of longstanding services available to individuals experiencing homelessness in Toronto, including supportive and alternative housing, emergency shelters, drop-ins, integrated street outreach services, housing help and eviction prevention services, and meal programs funded through three levels of government and the charitable sector. Also included in the homelessness service landscape is the City of Toronto's Streets to Homes program which began in 2005 and focuses on moving homeless individuals living outdoors into permanent housing (Toronto Shelter Support and Housing Administration, 2009).

A sizeable mental health service network serving homeless and housed individuals in Toronto is comprised of in-patient and outpatient care, case management, assertive community treatment, supported housing, supported employment, early intervention programs, court support services, crisis programs, and ethno-racial agencies, amongst other services.

Despite this, people who are homeless and living with mental health issues often face barriers to service access and end up using emergency room and inpatient hospitalizations for their care (Canadian Institutes of Health Research. *Reducing Health Disparities & Promoting Equity for Vulnerable Populations*. 2002). Existing mental health services often lack the resources or are unable to combine the basket of services and supports needed to address their needs, especially at higher levels of care (Stergiopoulos, Dewa, Durbin, Chau, Svoboda, 2010). Service fragmentation and lack of options for consumer choice often make it difficult to engage those with the most complex needs.

The Toronto Site is testing the following three approaches:

#### **iv) Housing First-Assertive Community Treatment**

The ACT intervention was originally planned to serve 100 high needs participants. The team approach to providing clinical supports and services is key feature of the model, aiming to deliver recovery-oriented support, treatment and rehabilitation. A key feature of the model includes peer support provided through a peer specialist. The ACT team is also comprised social workers, psychiatrists, psychiatric nurses, job development specialists, and a primary care physician. All participants are provided with continuous support and assessment. Participants have access to a team member or crises support services 7 days per week, 24 hours per day. Members of the team are provided close supervision.

## ii) Housing First-Intensive Case Management

The Housing First/Intensive Case Management Team utilizes a one to one service model for 100 moderate needs participants who are randomized to this intervention. ICM is a coordinated approach to comprehensive client-centered services. Each study participant is matched with a Case Manager, who works with each participant to develop a service plan that meets the individual's needs and is acceptable to him/her. Together they work on achieving goals that are important to the client through any of the following functions: outreach, assessment, skills teaching, network development, linking to resources, individual advocacy and crisis support. Service takes place in the community, typically at the location of choice for the participant. Case managers provide support services for participants 5 days a week, 8 hours per day, with after-hours crisis support as needed.

## iii) Housing First-Ethno Racial Intensive Case Management

The third arm of the Toronto project is an Ethnoracial Intensive Case Management (ER-ICM) program designed to meet the needs of homeless people with mental health problems from ethnoracial groups. This model provides the same basic support services as the regular ICM model but emphasizes a holistic approach to mental health care that recognizes the interdependence of spiritual, emotional, mental, physical, social, economic, cultural, linguistic and broader aspects of life in working with clients with severe mental health problems. Participants randomized to the intervention arm, who are eligible for ICM, and who identify as a member of an ethnoracial group, are given the choice to participate in the ER-ICM intervention arm. Programs and initiatives that integrate peer support, skills building, social and recreational activities, support groups, alternative and complementary therapies, art and music therapy, creative expressions, community kitchen, individual support and community outreach are available to participants in this intervention group. Assisting participants to build their support networks, including working with their family and friends is a main goal of this model. The ER-ICM service is provided from 8am- 8pm, 7 days /week based on client need. Aside from the ability of case managers to speak a second language, translation and interpretation services are purchased as needed.

## **b) Characteristics of the homelessness situation**

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

As demonstrated by the Street Needs Assessment, at any given night, there are more than 5,000 homeless people in Toronto. About 79% of them are living in shelters, 8% on the street, 4% in health care or treatment facilities, and 6% in correctional facilities (Toronto Shelter Support and Housing Administration, 2009).

Between one fourth to one third of homeless individuals in Toronto have a serious mental health problem such as schizophrenia, major depressive disorder, or bipolar affective disorder. A 2007 survey by Street Health found that about 35% of homeless people in Toronto reported a prior diagnosis of a mental health condition and 25% reported a combination of mental health and substance use problems (i.e. a concurrent disorder). Within the current system, a large proportion of these individuals do not receive the proper level of care for their mental health problems (Toronto Shelter Support and Housing Administration, 2006).

Mortality among homeless people in Canada is much higher than among the general Canadian population, and many unexpected deaths among homeless people in Canada are related to mental disorders and suicides (Hwang SW, Wilkins R, Tjepkem, O'Campo, Dunn, 2009). The average homeless person in Toronto will die before the age of 50 (ibid).

Based on the Street Needs Assessment conducted by the City of Toronto in 2006, the unmet need for specialized mental health services among homeless individuals in the Toronto area is significant and a large proportion of homeless people with mental health problems do not receive the proper level of care. Furthermore, immigrants, who make up about one third of homeless people in Toronto, in particular face significant barriers (e.g. racism, language barriers and stigma) to accessing mental health services (Access Alliance Multicultural Community Health Centre, 2005).

### **C) Homelessness in Toronto: Description of Care as Usual**

Clients suffering from serious mental health problems and homelessness access the treatment system in Toronto through many different entry points: inpatient and outpatient clinical services, peer support, crisis services, intensive case management, Assertive Community Treatment, supportive housing, vocational programming, street outreach programs, drop-in services and shelters.

While the service landscape in Toronto is typically characterized as having a wealth of available mental health services, it is estimated that only twenty-five to fifty percent of those eligible for services actually receive them. Although this may in part be attributed to a lack of capacity, it is also influenced by the absence of coordination amongst the existing services. There are ongoing efforts to develop a centralized access point for certain community services including case management, ACT, and supportive housing.

Many individuals who have serious mental health problems will be homeless at one time or another. Some are homeless repeatedly, and a small percentage is homeless for long periods of time. Many will end up in an inpatient mental health unit, at which time they may be referred for community based services such as ACT, case management or supportive housing. There are however long waiting lists for most community based services, which prevent the majority of individuals from accessing them on an immediate basis. Others will access a shelter or a drop-in that provides or has access to specialized services for mental health clients, such as Seaton House or Sistering, and will be connected to ongoing community services that way. The mobile crisis services that form a network across the city play an important role in engaging with consumers while they are in crisis and connecting them to services where possible. These programs are

increasingly recognizing the importance of establishing a presence in hospital emergency departments so that individuals who are not going to be admitted can be engaged, thereby shortening their wait in emergency.

There are approximately 4405 supportive housing units in Toronto specifically designated for individuals with serious mental health problems. The great majority of these are permanent housing with anything from an hour a week to 24 hours a day of support. Additionally there are many units available through what is referred to as the “alternative housing providers”, a group of providers who house individuals with a variety of health and social issues.

Over the past 10 years, several initiatives have been developed and funded by the Ministry of Health and Long-Term Care to better support those with greater challenges to successfully find and keep housing. The Mental Health Homeless Initiative of 2000 to 2002 provided about 1395 additional units of supportive housing (primarily existing housing, mostly scattered units with support) in Toronto for homeless individuals who have mental health problems. More recently, the Mental Health and Justice Initiative has added about 500 units of supportive housing, using a similar model of attaching supports and head leases to scattered units. These units are only available to homeless individuals with mental health problems who have recent involvement with the criminal justice system, and referral sources are specific to the justice system. Although these initiatives clearly had an impact on the identified populations, the permanent nature of the housing creates capacity issues once the units are filled.

Those individuals who remain on the street are engaged through services that provide an outreach component as well as through a network of drop-ins. Through Streets to Homes and its partner agencies, the individuals on the street are served through Intensive Case Management. Some Ministry of Health funded resources in street outreach and at drop-in centres also exist.

The Streets to Homes initiative in Toronto, which includes both city staff and contracted providers, is mandated to seek out and engage individuals who are living rough on the street and assist them to find housing. S2H uses Intensive Case Management and a Housing First philosophy, engaging, referring, housing and supporting the individual once they are housed. The city also funds a Mobile Multi-disciplinary Outreach Team (M-DOT) that takes referrals from S2H and its providers to work with those whose mental health problems and/or addiction issue is preventing the individual from engaging in a discussion about housing. The program has similarities to an ACT team in its multi-disciplinary approach but is relatively short term in duration, hooking clients up to other programs for follow-up once they are housed.

### **Community Health Centers**

Three downtown Community Health Centres – Parkdale in West Downtown, Queen West in Central Toronto and Regent Park in Southeast Toronto – are given \$6 million dollars a year in addition to their annual funding to hire staff (doctors, nurses, nurse practitioners, social workers, outreach workers), to work specifically with people who are homeless, and to coordinate services for people who are homeless between CHCs in the city.

Regent Park and Queen West CHC have an integrated approach to services, with clinical and outreach staff paid through the homeless funding developing work plans together, meeting

monthly and making recommendations to management. Queen West has created a forum of service providers in their area to enhance local services for the homeless. The CHCs are present on community and city networks related to the health, and related, issues of the homeless.

Unfortunately, the Ministry focused its attention on the problem of homelessness in the central core of Toronto but did not provide resources for the agencies to work with clients in the east end of the City, particularly Scarborough.

### **Drop-In Centres with On-site Medical and Psychiatric Services**

Most drop-ins have very limited resources for providing psychiatric or medical supports to their homeless service users living with serious mental health problems. The smaller drop-ins provide a safe space for social engagement and for accessing a broad range of necessities such as food, clothing, telephones, computers, laundry and showers. These drop-ins will have a small staff team to provide assistance in accessing care through referrals, eviction prevention supports and advocacy and, perhaps, an on-site nurse on occasion (i.e. from once every two weeks to one day per week). In some of the medium-sized drop-ins there will be a few specialist staff providing housing placement and maintenance supports.

A few larger drop-ins in Toronto, primarily those with Ministry of Health funding (of which there are six), have the resources to provide more extensive medical and case management supports to their homeless clients living with serious mental health problems. In these drop-ins, the largest staff team may have a few case managers (e.g., one of the largest has a mental health case manager, one addiction counselor and 2.5 trustee case management staff). Others may have housing support staff (e.g., one of the largest has 4 housing staff) to provide addictions, housing and mental health supports to the large number of people – 150 to 300/day depending on the location – coming in each day. These drop-ins also have limited but more extensive medical supports: one drop-in has a dental clinic; a number of drop-ins have a nurse on-site 1-4 days/week; one has a Concurrent Disorders Clinician on-site one day per week; another five currently have, through recent partnerships with St. Michael's Inner City Health, psychiatrists on-site one to two days per week, providing up to 5 hours per week of short-term care and psychiatric assessments for ODSP applications. In one drop-in working with Inner City Health Associates (ICH), for example, mental health staff in partnership with ICH and Ontario Works staff has been assisting participants to complete up to four ODSP applications per week, with the psychiatrist also providing short-term psychiatric care to 1-4 of the previously assessed individuals per week.

The few medical and case management staff in drop-in settings are often extremely busy and covering an unusually broad range of clinical needs. Thus, for example, the nurse working in one drop-in sees an average of fifteen individuals in a three-hour time period, with the work ranging from cleaning and bandaging wounds to mental health nursing. In almost all cases, while the case management and housing supports are part of the internal staff teams, the medical clinicians are from partner organizations like the Central Care Access Centre for nurses or ICH for psychiatrists or family doctors (of whom there are approximately 65).

The challenge is that those resources can be very precarious. Some drop-ins have experienced a regular turn over in nursing staff. Thus, in the very best resourced drop-ins, participants may be

able to access some medical services (primarily nursing, with very limited availability of psychiatric care or other clinicians), housing placement and maintenance staff, an addiction counselor and case management staff, though these staff will often be working with much larger numbers of individuals than one would find in the case loads of staff working in traditional case management settings in other Community Mental Health programs.

### **Supportive and Alternative Housing**

In the late 1970s into the early 1990s in Ontario, a number of unique non-profit organizations began to develop, own and operate housing with support for people who were considered to be in "deep core need" because they are economically disadvantaged and marginalized. Two streams of organizations responded to the need for safe, secure, permanent and affordable housing. One stream became known as "alternative housing providers", and the other became known as "supportive housing providers". These providers act as landlord, property manager and support agency. The difference between them is the degree of support provided, the funding source (with alternative housing it is the City of Toronto, and for supportive housing it is the Ministry of Health and Long Term Care for bricks and mortar and the Toronto Central LHIN for support), and the additional key eligibility characteristics defining who is selected for the housing with support opportunity.

Alternative housing tenants are defined less by their clinical diagnosis than they are by their homeless status. Tenants are referred directly from the streets, from shelters, hospitals and correctional facilities. Supportive housing tenants are defined by clinical diagnosis and the intensity of support required (high, medium, low) and which is provided directly by the supportive housing provider. High support typically means 24 by 7 staff presence and homemaking/meals on-site. Staff presence on-sites and other services offered determine medium and low support. Tenants are also referred from psychiatric institutions, hospitals, correctional facilities, shelters and the streets.

Alternative and supportive housing takes a number of forms including self contained apartments and private rooms in shared accommodation where kitchens, bathrooms, living rooms and kitchens are common. In some cases primarily in the boarding home segment of supportive housing, bedrooms may be shared as well. Units or apartments are located within buildings typically owned by both types of non-profit providers who are responsible for property management as well as support services. Affordability is through rent-gear-to-income subsidies administered by alternative and supportive housing providers. Alternative and supportive housing providers may also have rent supplements to access scattered or blocks of apartments in the private market rental sector. In this instance, case management services may fulfill the role of supportive housing provider managing the relationship with the private sector landlord.

The alternative housing providers' tenants are a diverse group, but are predominately single adults with low incomes who may live with mental health problems or addictions, or other social or health issues which present barriers to finding and maintaining stable housing. The supportive housing providers' tenants are diverse as well, with low incomes. They are predominantly single adults, have similar social or health issues affecting housing stability but must have a mental health diagnosis and may also live with addictions. In some instances supportive housing



providers also house couples and families with children as long as one member of the household meets the mental health/diagnosis criterion.

Alternative housing support services include; housing stabilization, eviction prevention, crisis intervention, referrals regarding income supports, employment and health care, including addictions and mental health services; and assistance with budgeting, homemaking, community living and personal care; conflict mediation and community development.

Supportive housing support services include functions of case management within a recovery framework and commitment to consumer choice housing stabilization, eviction prevention, crisis intervention, referrals regarding income supports, employment, primary health care and intensive clinical care, and assistance with life skills related to budgeting, homemaking, community living and personal care, conflict mediation and community development. Some supportive housing services include meals. Because of the complex needs of supportive housing tenants they have access to a flexible array of support services within and without the housing setting. Some may be clients of ACCT and have access to support staff of the supportive housing provider. Use of support programs and services is not a condition of tenancy however the alternative and supportive housing providers are able to respond quickly to emerging issues and crises because their staff are available.

**Ethno-Racial Services** include:

- Access Alliance, a community health centre for immigrants and refugees
- Across Boundaries, a mental health center for people of color
- The Canadian Mental Health Association, offering a variety of cross cultural initiatives
- COSTI, offering educational, social, and employment services to immigrants
- Hong Fook, a mental health association serving the Cambodian, Chinese, Korean, and Vietnamese communities
- Mount Sinai Hospital, home to an ACT team serving the SE Asian, Tamil, Aboriginal and Black communities
- Sistering, a drop in center serving low income women from various ethno-racial groups
- Sojourn House, the largest refugee shelter in Toronto, offering a variety of services and supports.

## **Appendix B: Housing First Logic Model**

### **Pathways Housing First: Logic Model**

This model is a graphic representation of the causal theory implicit in program operations as described by program managers (Figure 1). It describes the mechanisms that are believed to result in the desired outcomes as identified. The model may be useful for performing a normative evaluation, that is examining its actual implementation in the field, and assessing the congruency between the theoretical and the actual implementation; it may be used to test hypotheses about causal processes between the treatment and outcome; or it may be used to systematically identify or clarify a set of program goals or outcomes for facilitating the processes of program planning and management, as was intended in the construction of this model.

As a description of process, the model begins with outreach to identify individuals eligible for Pathways Housing First services. All individuals are offered scattered-site apartments as well as support services, enrolling in either Assertive Community Treatment (ACT) or case management depending on the individual's initial needs assessment. Upon intake, a care plan is prepared by an enhanced ACT team or case managers. In this program, ACT teams are extended beyond the typical fidelity standards specifying a staff of social workers, psychiatrist, and psychiatric nurse, to include a job development specialist and a primary care physician. In the case management model, staff broker with other providers in the community to provide additional support services.

Immediate changes in 5 areas believed to be critical in the recovery of the chronically homeless are as follows: 1) Immediate assistance in applying for public assistance and organizing the client's financial affairs to meet apartment lease eligibility requirements and to help the client prepare and manage household income; 2) An immediate working alliance connection between case managers and the clients in order to help the client identify his or her own treatment goals; 3) Assistance in identifying and accessing community health services for acute and chronic conditions; 4) Assistance in understanding job interests and job acquisition goals; and 5) Assistance in helping the client establish family, social, and spiritual connections, as desired by the client.

These immediate interventions are predicted to result in participation in addictions and mental health treatment, and reduced contact with non-supportive social contacts within six months. Subsequently, Participation in addictions treatment and reduction of contact with non-supportive social contacts is predicted to result in less abuse of alcohol or substances. A mediating variable of an increased subjective sense of well-being is predicted between increased participation in mental health treatment and reduced problematic drug use within 6-12 months. Similarly within this time-frame, access to community health services is predicted to result in increased participation in health problems management and self care. Access to client-centered job interests and development is predicted to result in increased participation in desired activities and employment search. Assistance in identifying and pursuing client-centered family, social, and spiritual connections is predicted to result in increased social support and community integration.

The connection between reduced problematic drug use and increased participation in health problems management, desired activities, and social support are not clearly connected to recovery as the effects are predicted to interact and ultimately result in recovery measurable in six domains within 12-24 months. Overall recovery is believed to be associated with reduced use of emergency response service calls, use of the emergency room for primary care, reduced number of arrests, maintenance of stable housing, reduced number of hospitalizations, and a general increase in physical health and quality of life.