# An Examination of Housing First Initiatives for Individuals with Concurrent Mental Disorders: Implementation and Feasibility

**Karen Parhar, Lisa M. Jewell, Kaitlyn Watson, Alexandra Kitter, and J. Stephen Wormith**

**Centre for Forensic Behavioural Science and Justice Studies**

**University of Saskatchewan and Kwantlen Polytechnic University**

**May, 2014**

UNIVERSITY OF SASKATCHEWAN

KPU | KWANTLEN POLYTECHNIC UNIVERSITY

# An Examination of Housing First Initiatives for Individuals with Concurrent Disorders: Implementation and Feasibility

**Karen Parhar**

***Kwantlen Polytechnic University***

**Lisa M. Jewell**

**Kaitlyn Watson**

**Alexandra Kitter**

**J. Stephen Wormith**

***Centre for Forensic Behavioural Science and Justice Studies,***

***University of Saskatchewan***

**May, 2014**

This study was funded by the Government of Canada's Homelessness Partnering Strategy, Employment and Social Development Canada.

Canada

## Acknowledgements

The researchers would like to thank all of the individuals from the participating organizations and residences: Canora Place/Jasper Place Health and Wellness Centre (Edmonton), Central Urban Métis Foundation Inc. (Saskatoon), McEwen Manor/Phoenix Residential Society (Regina), Pacific Coast Apartments/Coast Mental Health (Vancouver), The Lighthouse Supported Living (Saskatoon), Triage Shelter/Raincity Housing (Vancouver) who generously shared their time, perspectives and experiences with the research team. In particular, the research team would like to thank the following individuals for their support and assistance over the course of the project:

- Eunice Bergstrom, Director, Central Urban Métis Foundation, Inc. Wellness Centre, Saskatoon
- Carole Eaton, Executive Director, Phoenix Residential Society, Regina
- DeeAnn Mercier, Communications Director, The Lighthouse Supported Living, Saskatoon
- Adam Prytuluk, Manager, Triage Shelter (Vancouver)
- Giri Puligandla, Director, Planning and Research, Homeward Trust, Edmonton
- Tracy Schonfeld, Director of Community Services, Coast Mental Health, Vancouver

Thanks are extended also to the following students for their assistance with data collection: Craig Moore, Masters Student, Applied Social Psychology, University of Saskatchewan, Kimberly Paris, Undergraduate Student, Psychology, Kwantlen Polytechnic University, Storm Lee Sanders, Ph.D. Student, Interdisciplinary Studies, University of Saskatchewan, and to Ronda Appell, Coordinator, Centre for Forensic Behavioural Science and Justice Studies for her assistance with project coordination and administration.

## Disclaimers

The opinions and interpretations in this publication are those of the authors and do not necessarily reflect those of the Government of Canada.

This study is based in part on data provided by Alberta Human Services. The interpretation and conclusions contains herein are those of the researchers and do not necessarily represent the views of the Government of Alberta. Neither the Government of Alberta nor Alberta Human Services express any opinion in relation to this study.

## Table of Contents

## List of Tables

## List of Figures

## 1.0 Executive Summary

Supportive housing programs, particularly Housing First (HF) initiatives, have been strongly recommended for eliminating homelessness and have been found to be effective even with hard-to-house homeless populations such as individuals with concurrent disorders (ICMDs). However, a review of the literature and research documents indicate that little is known about the implementation of HF for ICMDs and whether these programs would be feasible to implement in smaller cities such as Saskatoon.

The overall objectives of the project are to:

- Identify what it takes to implement HF programs for ICMDs, including a critical analysis of how these programs bring together experts and link with institutions (e.g., hospitals).
- Identify how to adapt HF Programs in smaller centres that do not specifically serve ICMDs to better meet the needs of this population.
- Examine ongoing challenges and barriers to implementing HF for ICMDs in cities without it.

Housing programs in Vancouver, Regina and Edmonton were examined with a particular focus on HF and congregate supportive housing units for ICMDs. The evaluations involved key informant/stakeholder and client interviews, a review of existing databases/case files, and program documents. An outcome evaluation was also conducted in Vancouver comparing the outcomes of a congregate housing unit with a homeless shelter. Interviews were conducted in Saskatoon to examine the needs of ICMDs and the feasibility of implementing HF for this population in a city like Saskatoon. This portion of the research involved key informant/stakeholder interviews, community consultations, literature and document reviews, and case file reviews.

The key findings and recommendations for implementing HF for ICMDs that were derived from the evaluations of Vancouver, Regina and Edmonton were to:

- Create a community climate supportive of HF, particularly for ICMDs
- Build a long-term congregate supportive housing residence specifically designed to meet the needs of ICMDs
- Train staff
- Use evidence-based practices
- Bring together experts and make links to institutions
- Implement a decentralized system to access housing
- Make use of the *seven dimensions of quality for supportive housing*(CSH, 2013) for developing a HF model.

Based on the evaluation results and the review of the literature, an implementation model was developed. The four main phases of the implementation of HF are:

- Phase 1: Gain Support
- Phase 2: Obtain Resources
- Phase 3: Implement the Program
- Phase 4: Sustain the Program

The specific methods of achieving the goals of the four phases are also detailed.

Implementation of the model should take into consideration local context. In Saskatoon, several issues were identified that may influence the implementation of HF in the city such as the need to overcome resistance and discrimination, and to establish an atmosphere of change. As with any new program, funding will be another obstacle to implementing HF in Saskatoon. A need for a long-term supportive congregate housing unit for ICMDs with no barriers to entry, rooms dedicated to young men and 24-hour support is required in Saskatoon as there are currently very limited housing options for this group and there are long waitlists for supportive housing. More affordable housing options, staff training, and assistance with accessing services and finding housing was also identified as a need in Saskatoon.

To design and establish HF initiatives, it is important to identify key preconditions, common barriers, and factors that improve the likelihood that a program will become successful over the long-term. This project has the potential to ease implementation for future communities and allow limited resources to be used more efficiently and effectively. As a result, the results and outcomes of this project have the potential to make a significant long-term impact on homelessness in Canada.

## 2.0 Introduction

The following section provides some context and background for the evaluation followed by the specific research objectives.

### 2.1 Background of the Project

This project was funded by the Homelessness Partnering (HP) Secretariat at Employment andSocial Development Canada (ESDC). A call for proposals was disseminated in the summer of 2012 for projects that would increase knowledge about the prevention of homelessness for those with mental health issues in Canada after communities identified this as a research priority. Funding was available for projects that would enable a deeper understanding of homelessness prevention for those with mental health issues and contribute to the development of effective solutions to address the issue.

## 2.2 Definitions

*Housing First*

Utilizing a supportive housing approach, HF provides clients with permanent housing regardless of their mental health conditions, substance abuse, or agreement to participate in treatment (Tsemberis& Eisenberg, 2000). Housing is also immediate and low-barrier (Collins, Clifasefi, Dana, Andrasik, Stahl, Kirouac, & Malone, 2012). The core principles of HF are:

1) Immediate access to permanent housing with no housing readiness requirements
2) Client choice and self-determination
    a) Location of housing, type of housing and supports received
3) Recovery orientation
    a) Focuses on individual well-being and ensures clients have access to a range of supports that enable them to nurture and maintain social, recreational, educational, occupational, and vocational activities
    b) Access to a harm reduction environment
4) Individualized and client-driven supports
    a) Tailored to the individual, potentially ongoing, as determined by clients' acuity level; includes income supports and rent supplement
5) Social and community integration
    a) Opportunities for socially supportive engagement and participation in meaningful activities; housing models that do not stigmatize or isolate clients (Gaetz, Scott, & Gulliver, 2013)

These principles stress a need to change the system, rather than the person, and to respect clients in their choice to accept or reject clinical services (Gaetz, Scott, & Gulliver, 2013). They also stress a strengths-based model of treatment, focusing on life skills and support systems within the community. Housing First requires a holistic approach to housing that integrates all aspects of one's lifestyle and leads to positive self-evaluation and constructive community change (Topor, Grosso, Burt, & Falcon, 2013).

*Individuals with concurrent mental disorders (ICMDs)*

ICMDs, for the purposes of our study, are understood to be persons who are living with a mental health disorder in conjunction with an addiction. A mental health disorder is defined more specifically as an Axis I or II disorder, such as: an acquired brain injury; fetal alcohol spectrum disorder (FASD) or post-traumatic stress disorder. An addiction is defined as an alcohol abuse or dependence disorder or a substance abuse or dependence disorder (American Psychiatric Association, 2000).

## 2.3 Literature Review

It has been estimated that as many 50,000 of Canadians are homeless on any given night (Gaetz, Donaldson, Richter, & Gulliver, 2013). Investigations into homelessness as both a personal and social problem have indicated that a large portion of those who are without a home is made up of individuals with concurrent mental disorders (ICMDs).

Across Canada there are as many as 520,700 people living with mental health illnesses who are living in inadequate housing and nearly 119,800 are homeless (Mental Health Commission, 2012). In Canada approximately 20% of those who seek medical attention for mental health issues will also be living with an addiction, and for more than 50% of those seeking help on substance abuse will have mental health concern.

It has been widely documented that individuals with concurrent mental disorders are over-represented among homeless populations as they become stuck in the "revolving door" of homelessness, criminal justice, and acute healthcare system contacts (Patterson et al., 2013). Those with concurrent disorders experience higher chance of homelessness, criminality, and marginalization. This makes concurrent mental health disorders a significant issue for the Canadian healthcare and housing system (Mental Health Commission, 2012). In '*The State of Homelessness in Canada 2013*' (Gaetz, et al., 2013), it was estimated that the annual cost of homelessness for the Canadian economy is $7.05 billion dollars, half of which is being used by only 15% of the homeless population. It may be deduced from this information that effectively treating and housing this population will significantly lower the cost of homelessness in our nation, many of whom may be ICMDs. While the needs of this population are extremely complex, it is important we try to understand the most effective forms of treatment and housing models that can support ICMDs in their search for, and maintenance of, stable housing.

There are currently two service models within the mental health system for homeless ICMDs. The most popular model used today is the residential continuum model (Tsemberis& Eisenberg, 2000). This approach defines success on a continuum that begins with treatment compliance, leads to psychiatric stability and abstinence from substance abuse, and ends with permanent housing. The only way to gain access to housing is to first succeed at the other challenges. Housing First, on the other hand, utilizes a supportive housing approach. Housing First was originally developed in the early 1990s by Pathways to Housing Inc. in New York City and refers to a specific type of housing based off of their design (Watson, Wagner, & Rivers, 2012). The model was founded on the belief that "housing is a basic human right for all individuals, regardless of disability" (Tsemberis& Eisenberg, 2000, p.488).

The HF approach provides clients with permanent housing regardless of their mental health conditions, substance abuse, or agreement to participate in treatment (Tsemberis& Eisenberg, 2000). Housing First is defined by an adherence to a number of key concepts,

and model fidelity is an important aspect of replicating the program across the country and internationality to ensure that the model does not drift away from these core concepts. Housing First programs, however, operate in specific contexts influenced by culture, values and resource availability that go beyond the fidelity of these elements to a number of other program and client outcomes. Tailoring the HF model to unique local contexts can represent an enhancement on the model itself as opposed to undesirable model drift (Stafancic, Tsemberis, Messeri, Drake & Goering, 2013).

In the HF model, housing itself is used as an intervention for homeless ICMDs (Henwood, Stanhope, & Padgett, 2010). Clark and Rich (2003) evaluated the effectiveness of both HF and traditional service programs in their ability to reduce homelessness among individuals with severe mental illness among 152 participants. In a 180-day period, those who were highly impaired increased their amount of time spent in stable housing by an average of 52 days while those in the HF program increased their time by an average of 106 days, which is an increase of more than 100 %. Evidently, ICMDs with complex needs are more likely to succeed in programs that follow the HF model. These results are in line with HF expected outcomes, which are the following: housing tenure, quality of life, community integration, recovery and a reduction in the usage of emergency services (Keller et al., 2013).

More specifically, one of the defining principles of HF is that clients are able to choose where they live and the type of housing in which they live. In fact, resident choice in housing options has been associated with increased housing satisfaction, stability, and psychological wellbeing (CHMC, 2002). The continuum of choices that may be presented to clients range from institutional settings to congregate housing to scattered site housing. Supportive housing programs appear to be a nearly ideal type of program to reduce homelessness (Federation of Canadian Municipalities, 2008). Similarly, Health Canada's document, "Best Practices Concurrent Mental Health and Substance Use Disorders", supports an "integrated approach" to the treatment of Concurrent Disorders. Integrated approaches have linkages between facilities and service providers so that effective interventions can be planned and implemented in a coordinated and concurrent fashion. HF, in particular, is strongly recommended for eliminating homelessness (Federation of Canadian Municipalities, 2008). Most studies on implementing HF have not focused specifically on ICMDs; however, many studies have focused on populations with serious mental illness, which are likely to include ICMDs.

Based on the studies reviewed, HF Initiatives appear to align with the needs of homeless ICMDs. Individuals with concurrent mental disorders are an important focus for HF not only because they are over-represented among homeless populations but because they may have greater support needs related to psychiatric, mental health, and substance abuse treatment. This support would include treatment that integrates mental health and substance abuse treatment and a range of varying levels of supports to match clients'

acuity. Individuals with concurrent mental disorders may also have unique housing needs within a HF model. In order to be successful, HF initiatives need to be implemented effectively. A number of Housing First programs have been implemented in Canada and across the world (Gulliver, 2014). Lessons learned from these HF case studies are discussed in section 7.1 when describing the implementation model.

### 2.4 Research Objectives and Activities

*Objectives*

The overall objective of this research is to identify what it takes to implement an effective HF program for ICMDs and to determine the feasibility of implementing these programs in cities without them, with a particular focus on Saskatoon, Saskatchewan. The research also included:

- A critical analysis of how existing supportive housing programs bring together experts and link with institutions to help prevent ICMDs from becoming or remaining homeless.
- Challenges, barriers and lessons learned.

*Research Activities*

The project spanned from November 2012 to March 2014. Key activities included (1) establishing a project advisory committee of stakeholders; (2) conducting process evaluations in Vancouver, Regina and Edmonton and an outcome evaluation in Vancouver and (3) conducting a needs assessment in Saskatoon. The final two months focused on developing dissemination tools and presenting the results. Community consultations in Saskatoon disseminated the results and allowed discussions of the feasibility of implementing key components and best practices of supportive housing programs for ICMDs. The community consultation outcomes were integrated into the results of the research.

The results are based on case studies from three Canadian cities with a particular focus on HF and congregate housing units for ICMDs. The lessons learned from the case studies informed the development of an implementation model. The feasibility of implementing HF in the local Saskatoon context and the application of the HF model to Saskatoon was also discussed.

## 3.0 Research Design and General Methodology

Although the overall objective of this research focuses on the implementation of HF programs for ICMDs and to determine the feasibility of implementing them, the fact is that HF in its ideal form has not been implemented widely across Canada at this time.

However, assessing how ICMDs are successfully housed in cities without HF programs can also inform the implementation of HF programs. Therefore the current research assessed the implementation of a HF program in Edmonton with a specific focus on ICMDs and housing for ICMDs in Vancouver and Regina. Although Vancouver does not currently have a Housing First program in place, the At Home/Chez Soi demonstration project implemented a Housing First model in Vancouver from 2009-2013. Although Vancouver currently does not follow a HF Model, it was selected because it has many elements that are consistent with a HF approach and has a large supportive congregate residence with a large proportion of ICMDs. Regina also does not follow a HF model, but was selected because its size and demographics are similar to Saskatoon and it also has a congregate supportive housing unit specifically designed for ICMDs. The broader housing issue in each city was assessed in addition to a specific focus on residences with a large proportion of ICMDs in order to inform how HF programs can be successfully implemented.

The project involved various evaluation methods across the different sites and data were collected using a variety of methods. This section describes the general methodology of each evaluation. Specific details of the methods used at each site are provided in their respective sections.

*Process Evaluation*

A process evaluation was conducted on the housing programs being evaluated in Vancouver, Regina and Edmonton. The process evaluation involved staff, key stakeholder and client interviews, a review of existing databases/case files, and program documents to develop case studies at each site that examined implementation procedures, service coordination, and sustainability of the programs. More specifically, the process evaluation involved:

1) A document analysis to describe the programs (including wait list times, length of stay, discharge plan development procedures, program costs);
2) Staff, key stakeholder and client interviews to examine implementation, referral procedures, service coordination, and sustainability of the programs; and
3) A database or case file review to determine program costs, client outcomes (e.g., frequency of program use, service use, length of service use, psychiatric symptom severity, medication use, income)[1].

*Outcome Evaluation*

An outcome evaluation was also conducted on Pacific Coast Apartments in Vancouver. The outcome evaluation compared the outcomes (e.g., length of stay,

[1]Not all data were available at all the sites.

behaviour, etc.) of ICMDs at Pacific Coast Apartments with a comparison group of ICMDs who were currently in the Triage homeless shelter in Vancouver, British Columbia.

*Assessment of Need and Feasibility*

In Saskatoon, an assessment of need and feasibility was conducted that uses lessons learned on implementation and best practices from the literature review as well as the process and outcome evaluations. The assessment involved key informant/stakeholder interviews, community consultations, literature and document reviews, and a case file review. More specifically, assessment data were collected using (1) stakeholder, client, staff, and key informant interviews to determine the need for supportive housing for ICMDs in Saskatoon; (2) a case file review to determine client characteristics of supportive housing programs in Saskatoon; and (3) community consultation to identify barriers and opportunities and examine the feasibility of implementing key components and best practices for improving services for ICMDs in Saskatoon.

Data were analyzed using qualitative and quantitative methods. Statistical analysis was conducted on quantitative data and thematic analysis was conducted on qualitative data. All evaluations were conducted in English.

*Community consultation*

In mid-March, a community consultation was conducted to obtain feedback about the implementation model that was developed in (See Section 7.1), as well as its application to the Saskatoon context. In particular, the application of the model to the Saskatoon context centred around what aspects of the model were already in place and what was still needed for the model to be implemented in Saskatoon (See Section 8.0). The questions and concerns of community members similarly focused on a comparison of Saskatoon's services to those available in the sites studied and the feasibility of implementing the model in Saskatoon. Feedback from the community consultation was integrated into the report.

## 4.0 Pacific Coast Apartments (Vancouver): Process and Outcome Results

The following section describes the process and outcome evaluation conducted at Pacific Coast Apartments in Vancouver, British Columbia.

## 4.1 Methods

### Process Evaluation

*Key Stakeholders/Informants*

Six key stakeholder/informant interviews were conducted. The key stakeholders/informants interviewed had approximately 10 years of relevant experience and worked at the following agencies: Pacific Coast Apartments (PCA), Coast Mental Health (CMH), Assertive Community Treatment (ACT) outreach, and the Mental Health Commission.

*PCA Residents*

Ten residents were interviewed and all agreed to a case file review. The mean age of the participants was 45. Most of the participants were male (*n*=9) and Caucasian (*n*=8). On average, the participants were residents at PCA for 16 months. Information about educational backgrounds and current employment was very limited and almost never reported.

*Document Review*

A document review was conducted to describe PCA. A research assistant reviewed the following documents for the document review:

- Pacific Coast Apartments website
- Local newspaper online articles
- House rules binder
- White boards located in office
- Training manual
- Program information binder

### Outcome Evaluation

Thirty-three PCA residents signed consent forms and agreed to participate. Of these, 9 were excluded because they did not have concurrent disorders, resulting in a total of 24 participants.

Twenty-six residents of Triage Shelter in Vancouver signed consent forms allowing the researchers to access their case files. Of these, 12 were excluded because they did not have concurrent disorders, resulting in a total of 14 participants.

### 4.2 Program Description

Founded in 1972, CMH is a non-profit organization operating in British Columbia. Coast Mental Health provides services like housing, employment, education, external resources and links, financial trusts, and youth services to individuals who are recovering from a serious mental illness (Coast Mental Health [CMH], n.d.-a). Coast Mental Health operates more than 20 housing developments in Vancouver, Burnaby and Surry in partnership with federal, provincial and other funding partners, and offers a variety of supportive housing to approximately 1200 people. This includes community housing and cottages for individuals with a mental illness who were involved in criminality but deemed "not guilty due to mental defect" (Coast Mental Health [CMH], n.d.-b).

Pacific Coast Apartments is one of 14 sites the City of Vancouver has provided for affordable housing. Pacific Coast Apartments provides 96 compact and affordable apartment suites, as well as support services, to individuals who are homeless or at risk of becoming homeless. More specifically, the residence is designed for homeless youth and adults, people with mental illness, HIV/AIDS or addictions (Canada Mortgage and Housing Corporation [CMHC], 2013). To live at PCA, residents must be 19 years of age or older; have been referred from a designated referral source (e.g., BC housing); and are capable of living independently (that is, without live-in staff and constant supervision). Residents must also comply with the rental agreement, be in financial need and require a rental subsidy. (CMH, n.d.-b).

Pacific Coast Apartments is a nine-story building with 1 floor dedicated to hard to house youth, 1 floor dedicated to HIV/AIDS patients and 1 floor for females. There are 14 beds designated for Inner City Youth program that accepts clients aged 16-25 years old. There are 25 beds dedicated to HIV/AIDS patients. At the time of this evaluation there were 70 male and 26 female residents. The main goal of PCA is to provide housing. Pacific Coast Apartments also aims to help residents with goal setting and provide a safe environment.

Pacific Coast Apartments was developed by CMH and funded through the Canada-British Columbia Housing program. The building was funded by the Government of Canada ($ 5,500,000) and the Government of British Columbia ($12,600,000 in a grant and 1,200,000 annually for the cost of operations). The City of Vancouver provided the land to PCA valued at $1,950,000 and reduced the project's development fees by $331,000. Coast Mental Health can lease the property for $1 a year for the next 60 years (CMHC, 2013).

Construction began in March 2010 and the building opened in May 2011. Pacific Coast Apartments was designed as a demonstration for small-suites with the goal of accommodating more people in the available space. The construction of the building

encountered logistical issues in terms of the narrow lot as well as accommodating plumbing and utilities into several small suites. While the rooms are 25% smaller than an average bachelor apartment, there are three suite sizes available to choose from ranging from 225 to 400 square feet (CMHC, 2013). There are also some rooms at 450 square feet geared towards accessibility and large common spaces at PCA devoted to socializing and programs. The building, furthermore, incorporates features (e.g., solar panels, high efficiency windows and ventilation system) designed to be environmentally friendly, lower operating costs and increase occupants' well-being (CMHC, 2013).

Pacific Coast apartments hosts a variety of optional recreation programs including sports, walking groups, art, writing, movie nights, music lessons, yoga, along with many other activities. Resident-run mindfulness relapse prevention groups are encouraged weekly as well as staff run health and wellness lessons. The medication distribution program, run by community mental health staff, is also available to residents who would like help with administering their medications on time and in correct dosages. Meals and snacks are also available to residents. Staff at PCA provides help to residents with cleaning their suites, as well as ensuring safe room conditions such as bug and pest control. Building operators provide services to help maintain a safe environment by doing routine maintenance.

Staff at PCA is comprised of 1 program coordinator, 6 Community Mental Health Workers (CMHWs), and 13 building operators. Employees are hired through postings internally, or externally through Coast Mental Health. Community Mental Health Workers are responsible for the delivery of housing and support services, enabling residents to enter, maintain and exit (where appropriate) supported, independent living, by use of the principles of psychosocial rehabilitation practices. CMHWs may also be responsible for medication distribution, daily operation of social, recreational, work and food programs, and ensuring the safety and welfare of residents in the program. A building operator performs a variety of cleaning, landscaping, and interior and exterior maintenance duties assigned by Coast Properties Department. Routine education and training is mandatory for PCA staff and their performance is reviewed annually.

Since opening in 2011, 29 residents were discharged from PCA. As such, 70% of the residents were housed since PCA opened in 2011. Discharges were for the following reasons: guests ($n$=4), non-specified reason ($n$=4), deceased ($n$=4), moved to other housing ($n$=3), rent ($n$=3), did not renew tenancy ($n$=2), damage to property ($n$=1), pest control ($n$=1), noise complaints ($n$=1), verbal abuse to staff ($n$=1), move out to other BC housing ($n$=1), move within Coast ($n$=1), subsidy with ICY ($n$=1), back at tertiary care ($n$=1), and palliative care ($n$=1). Seventeen residents or 58.6% of the discharges or 17.7% of the total number of tenancies were considered unsuccessful (e.g., rule violations such guests, rent, verbal abuse, etc.).

Although Vancouver currently does not follow a HF Model, it has many elements that are consistent with a HF approach (Regional Steering Committee on Homelessness, 2013). Supportive housing units for ICMDs using a HF approach and outreach teams have been in place for decades and have been increasing over the last 10 years. In addition, PCA has no housing readiness requirements and when being housed in Vancouver, client choice is taken into consideration regarding location of housing and type of housing (although this also depends on what is currently available). The residence has a recovery orientation which focuses on individual well-being and ensures residents have access to a range of optional supports that enable them to nurture and maintain social, recreational, educational, occupational, and vocational activities. In addition, PCA provides access to a harm reduction environment, individualized and client-driven supports and social and community integration.

*How a Homeless Individual Accesses Housing in BC*

Vancouver uses a centralized system of housing the homeless. A single point of entry into the system is through the Supportive Housing Registrations service, which is funded by BC Housing. The goal of using a single point of entry is to facilitate the registration process (registering once rather than multiple times with each housing provider). Eligible applicants to Vancouver's system are low income adults who need support services to stay housed and:

- Are homeless or at risk of homelessness;
- Have mental and/or physical health needs;
- Require safe and affordable housing; or
- Are current tenants in supportive housing that are applying for a transfer to a housing location that is better suited to their needs.

Eligible clients can download an application, or be assisted at BC Housing offices or non-profit agencies that help individuals in their search for housing (BC Housing, n.d.-b).

Homeless individuals can also use the services of an outreach worker. An outreach worker works to address a client's immediate physical and safety needs. This may include a number of components, such as: helping to get food, warm clothing and finding a place to stay. This can also mean connecting clients with housing and income support; making appointments; accompanying clients at appointments. Outreach workers can also connect clients to other support services, such as: life skills training, personal health, household and financial management; as well, they may act as a landlord liaison (BC Housing, n.d.-a).

### 4.3 Demographic Profile of ICMD Residents

Ten residents of PCA were interviewed. Nine of the participants had a substance abuse or dependence disorder. Six of the nine were diagnosed, two were self-reported and one was suspected by staff. The most common substances abused were cocaine/crack (*n*=5), cannabis/marijuana (*n*=4), crystal meth (*n*= 3) and heroin (*n*=2). Five participants abused alcohol. Two of the five were diagnosed and three were suspected by staff.

All of the participants had at least one suspected mental health disorder. Eight of the 10 had a diagnosed mental disorder. The most common diagnosed mental health disorders were depression (*n*=5) and anxiety (*n*=3). Of the participants without a diagnosed mental health disorder, one self-reported having depression and one was suspected by staff of having some undetermined mental health disorder.

### 4.4 Success and Barriers

The successes and barriers that emerged from process and outcome evaluation conducted at PCA are listed below.

*Success: Effective Supportive Housing Methods Used at PCA*

**PCA is achieving its goal of housing ICMDs.** Residents at PCA were housed for longer periods (476 days) than residents at Triage (37 days) even though they did not differ in gender and age. All the participants had concurrent disorders and similar housing backgrounds. On average, residents lived at PCA (1 year and 3 months) longer than residents at Triage (just over a month). Some residents at PCA were there since it opened. Triage Shelter had significantly more participants discharged than PCA (71% vs. 8%) and Triage discharged residents to less stable accommodations (i.e., the streets), whereas PCA did not.[2]Residents at PCA only entered PCA once, whereas residents at Triage Shelter entered Triage Shelter an average of 3.4 times. Overall, ICMD residents at PCA state they are satisfied at PCA. Residents liked PCA because it is clean, quiet, safe, and secure and has less drug use than previous living situations.

**PCA follows a Housing Firstmodel.** Pacific Coast Apartments houses many high risk/high need homeless ICMDs and there are no barriers to being housed at PCA. Individuals with concurrent mental disorders at PCA have a long history of homelessness and almost all participants had a variety of mental health, substance abuse and physical

[2]Residents at Triage (100%) were significantly more likely to make housing plans than those at PCA (33%).Residents at Triage (86%) were significantly more likely to make efforts to secure more stable housing while residing at the residence than those at PCA (29%).

health issues. Interviews indicate that many residents were on the streets for a long time prior to moving to PCA. Residents and stakeholders indicated that a strength of PCA was that it provides a variety of services to foster individual needs (e.g., residents have input on programs and services). In addition, PCA provides individualized case management to address the needs of ICMDs.

**PCA accepts 'best fit' clients rather than using waitlists.** Fifty percent of key stakeholders stated that the least effective referral procedures were from BC Housing and the most effective were from partners who are familiar with PCA and know who is most suitable for the services they provide. Key stakeholders felt that those housing ICMDs need to know the client's limits and abilities in order to house them in an appropriate environment. Key stakeholders also stated that giving clients a choice on where they will be housed helps them obtain a better fit, and thus, they will be more likely to be housed successfully.

**PCA provides a range of services, resources and support.** Pacific Coast Apartments provides in-house medication distribution, meals, activities, support staff and resources for residents. Eight out of 10 of resident participants stated that PCA was best housing they have had, in part due to the meals provided, medical services, and other services provided. Pacific Coast Apartments residents were referred from a variety of sources indicating many agencies knew about PCA. Furthermore, PCA staff are required to know what supports are available in the community so they can help their residents find appropriate services and activities. Residents are given opportunities to volunteer at PCA and a variety of other community service facilities.

**PCA involves multi-disciplinary teams and has connections with community resources and services.** A consistent strength mentioned at PCA, is that it has linkages with many housing agencies that work together to provide multiple opportunities for staff and residents. Pacific Coast Apartments provides connections between outreach and BC Housing so they can help a resident transition smoothly when exiting the residence and ensures they are discharged to an appropriate residence. Pacific Coast Apartments brings together experts and links to institutions through a variety of methods**.** For example, multi-disciplinary teams provide on-site servicesand PCA participates in joint training with other CMH housing agencies that involves speakers from places such as hospitals, community programs, and police departments. Another positive aspect of PCA is that outreach workers can see resident files, get to know doctors and others involved in helping the resident. In addition, PCA works with the Inner City Youth (ICY) Program and the STOP HIV/AIDS Team. These designated teams work with individuals who have specified needs. For youth, ICY works with issues related to mental health and the specific needs of 16-25 year olds. Those in STOP are helped with issues specific to HIV/AIDS. These individuals need more specific care than others and these teams ensure they receive it.

*Challenges and Barriers*

Few challenges or barriers were mentioned about PCA. However, the most common are listed below:

**The BC Housing Registry was found to be ineffective and not utilized.** The waitlist was not utilized. Service providers communicated with one another to provide housing to those most in need and those who were a good 'fit' for the residence.

**Staff turnover.**Staff turnover was another consistent challenge mentioned by residents. Residents worried about staff leaving after they had established a trusting relationship, especially as it took a while for residents to begin to trust staff.

## 5.0 Canora Place(Edmonton): Process Results

The following section describes the process evaluation conducted at CanoraPlace (CP) in Edmonton, Alberta.

### 5.1 Methods

*Key Stakeholders/Staff*

Seven key stakeholders and staff were interviewed from: Jasper Place Health and Wellness Centre, CP, Homeward Trust, the City of Edmonton, as well as a member of the Canora community.

*Canora PlaceResidents*

Eleven CPresidents were interviewed. Client (resident) interviews were supplemented with some case file information (gender, age, date of birth, education, total household income, marital status and number of children), which was available for eight of the eleven residents.

*Document Review*

An extensive documentreview was also conducted. The following sources were reviewed for inclusion in the Edmonton process evaluation:

- Alberta and Edmonton 10-year plans for ending homelessness
- Homeward Trust reports, including annual reports
- Homeward Trust website
- Edmonton Homeless Count
- Homeward Trust website
- CanoraPlace policy document
- Canadian Homelessness Research Network documents

*Case File Review*

Eight residents consented to a case file review. Case file data were compiled from information provided by two sources: the Ministry of Human Services'Homeless Management Information System (HMIS),and Homeward Trust's Efforts to Outcomes, a system that provides up-to-date information on residents for Edmonton service providers.

### 5.2 Edmonton HFContext

Edmonton is one of seven cities[3] in Alberta chosen to implement Alberta's 10-year plan to end homelessness (*A Plan for Alberta: Ending Homelessness in 10 years*). Alberta is the only province in Canada with a plan to end homelessness. Officially, the plan began April 1, 2009. The Government of Alberta created the Alberta Secretariat for Action on Homelessness to develop "a comprehensive, co-ordinated and sustainable approach" as well as establishing goals, timelines and financial requirements. The Alberta plan is guided by a HF philosophy where investments are focused on the following three areas:

- **Rapid re-housing**
    - A focus on bringing homeless individuals from the streets and shelters into permanent housing.
- **Providing client-centred supports**
    - Providing assistance to clients needed to restore their stability and maintain housing.
- **Preventing homelessness**
    - Providing emergency assistance and government programs and services to Albertans (Alberta Secretariat for Action on Homelessness [Secretariat], 2008).

Each of the seven cities was given an envelope of funding by the province and adopted different models to manage the funds. Edmonton and Calgary use non-profit organizations to manage the funds, whereas in the other cities, the funds are managed by the City. Edmonton's 10-year plan (*A place to call home*) started out as a Mayor's Task Force. The Task Force was comprised of individuals who had little experience with homelessness but had a lot of influence in the city. The Task Force signed off on the plan and established the Homeless Commission, a committee of the Edmonton City Council, to champion Edmonton's plan. The Commission reports yearly to the Mayor and Council on its progress in implementing the plan. As the Commission is community-based; however, no municipal funds are associated with the municipal 10-year plan (Edmonton Committee to End Homelessness, 2009).Many of the Commission's activities are therefore funded or coordinated by Homeward Trust.

[3] Edmonton, Calgary, Red Deer, Lethbridge, Grand Prairie, Fort McMurray and Medicine Hat

### 5.3 Program Description

*Homeward Trust – Implementation and Coordination Responsibility for 10-year Plans in Edmonton*

In Edmonton, Homeward Trust (HT), a non-profit organization established in 2008, acts as the community-based organization responsible for implementation of the provincial 10-year plan and a key contributor to progress on the City of Edmonton's ten year plan, which took 1.5-2 years to develop. Homeward Trust coordinates or funds most programs and activities related to ending homelessness in Edmonton on behalf of federal and provincial governments. The City of Edmonton also provides funding separately through City administration (e.g. Community Services for street and parkland homeless outreach) and the Edmonton Homeless Commission. Homeward Trust plays a reporting role and sends the Commission data yearly for their report to the Mayor and Council. Homeward Trust does not, however, sit on the Commission's board, although Homeward Trust's CEO is an ex officio member (Edmonton Homeless Commission, n.d.). Homeward Trust has a mandate to:

- Increase access to housing
- Coordinate the provision of support services
- Undertake planning and research
- Raise awareness in the community to promote ending homelessness in Edmonton (Homeward Trust, 2012a)

Since its creation, Homeward Trust has been funded $79,000,000 through the Government of Canada's Homeless Partnering Strategy. The Government of Alberta has given $43,000,000 and the City of Edmonton has put forward $26,000,000. Other funding comes from philanthropic, corporate, and other donors from the general public (Homeward Trust, n.d.-b). The Province of Alberta also allocates $20,000,000 - $25,000,000 a year to the ACT and ICM teams.

Homeward Trust's key messages are:

- Housing – the main ingredient
- Wrap-around support
- Aboriginal Focus

Housing is a starting place: client are not required to overcome their addiction before being housed but rather are provided a home so that they may work at overcoming their addiction from a place of stability (Homeward Trust, 2012a). Wrap-around support, includes any supports that are needed for clients to maintain housing. Supports could include furniture and financial support or social supports in the form of life skills and

community connections. Help with gaining access to training and employment opportunities, health and criminal justice, family reconnections, money management and psychiatric or substance abuse issues are other forms this support could take. The Board's composition and Aboriginal Advisory Council aid Homeward Trust's Aboriginal focus.

Homeward Trust's governance structure is an important part of its functioning. Homeward Trust employs more than 35 staff in their main office. The following (Figure 1) is an organizational chart of HT's organizational structure(Canadian Homelessness Research Network, n.d.).

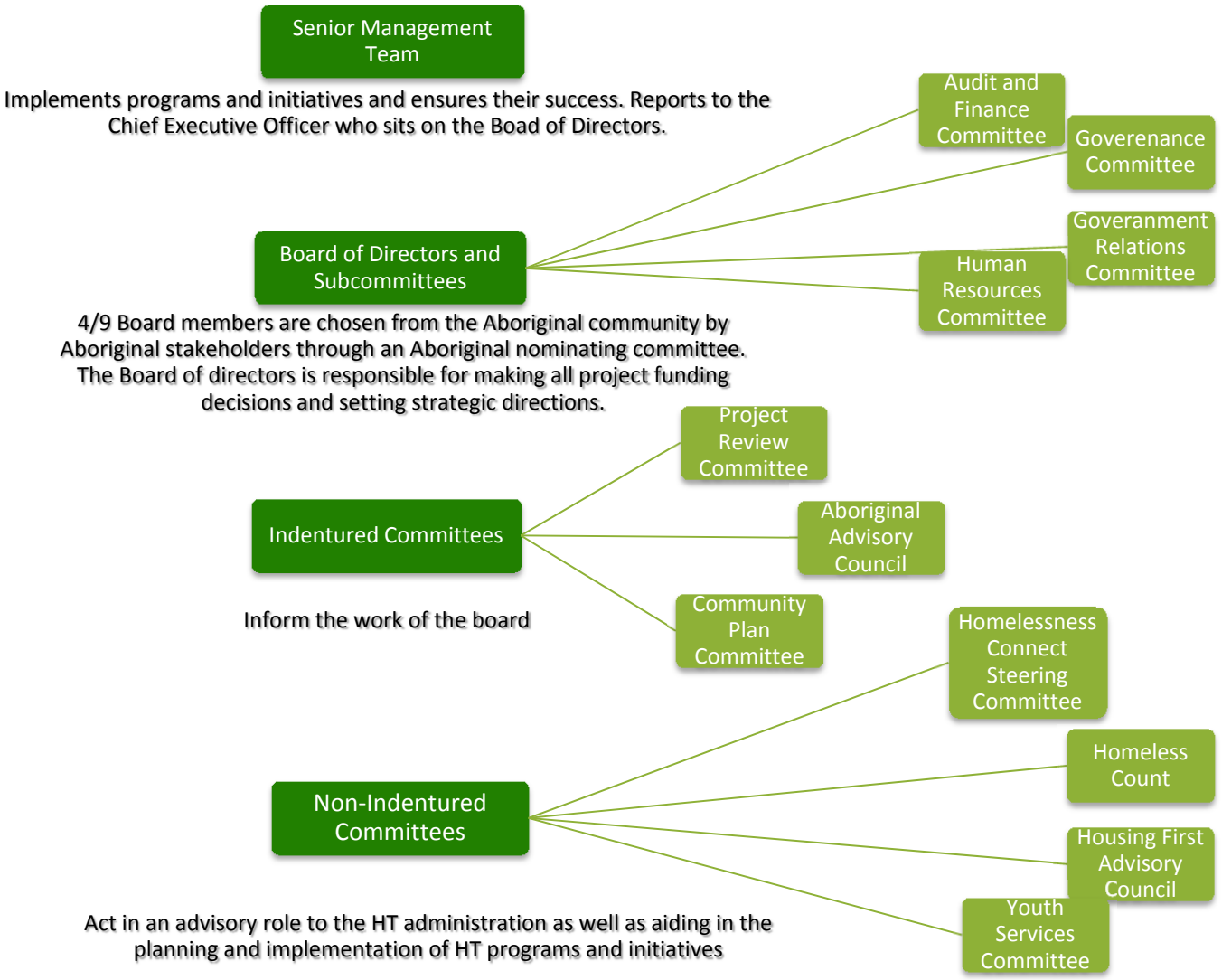



*Figure 1*.Homeward Trust organizational structure**.**The committees and subcommittees are depicted in dark and light green respectively. Listed below each committee is a brief explanation of its purpose.

Homeward Trust plays a key role for local research and evaluation on the 10-year plan. Homeward Trust uses the Efforts to Outcomes (ETO) case management and data collection system to gather data from the organizations it funds, as part of its focus on an evidence-based/data driven process, to keep track of clients' progress in the program in order to better meet their needs and to provide real-time community-level data to stakeholders and policy makers. Homeward Trust also uses the Service Prioritization Decision Assistance Tool (SPDAT), which is integrated into ETO. The SPDAT is a tool developed by OrgCode to guide outreach workers and ICM teams. The tool was designed to prioritize which clients should receive HF intervention next; to match clients' needs to staff strengths; to assist team leads in establishing priorities; to assist with case planning; to track the depth of need and service responses to clients over time, and to prioritize the time and individual attention of frontline workers. The SPDAT has not been designed to provide a diagnosis, to assess a client's current or future risk or to replace valid and reliable instruments used in clinical research and care. The SPDAT is only to be used with clients who meet program eligibility criteria (e.g. homeless at intake) (Homeward Trust, 2011). Homeward Trust is also the primary funder of HF services provided in Edmonton (See Figure 2).

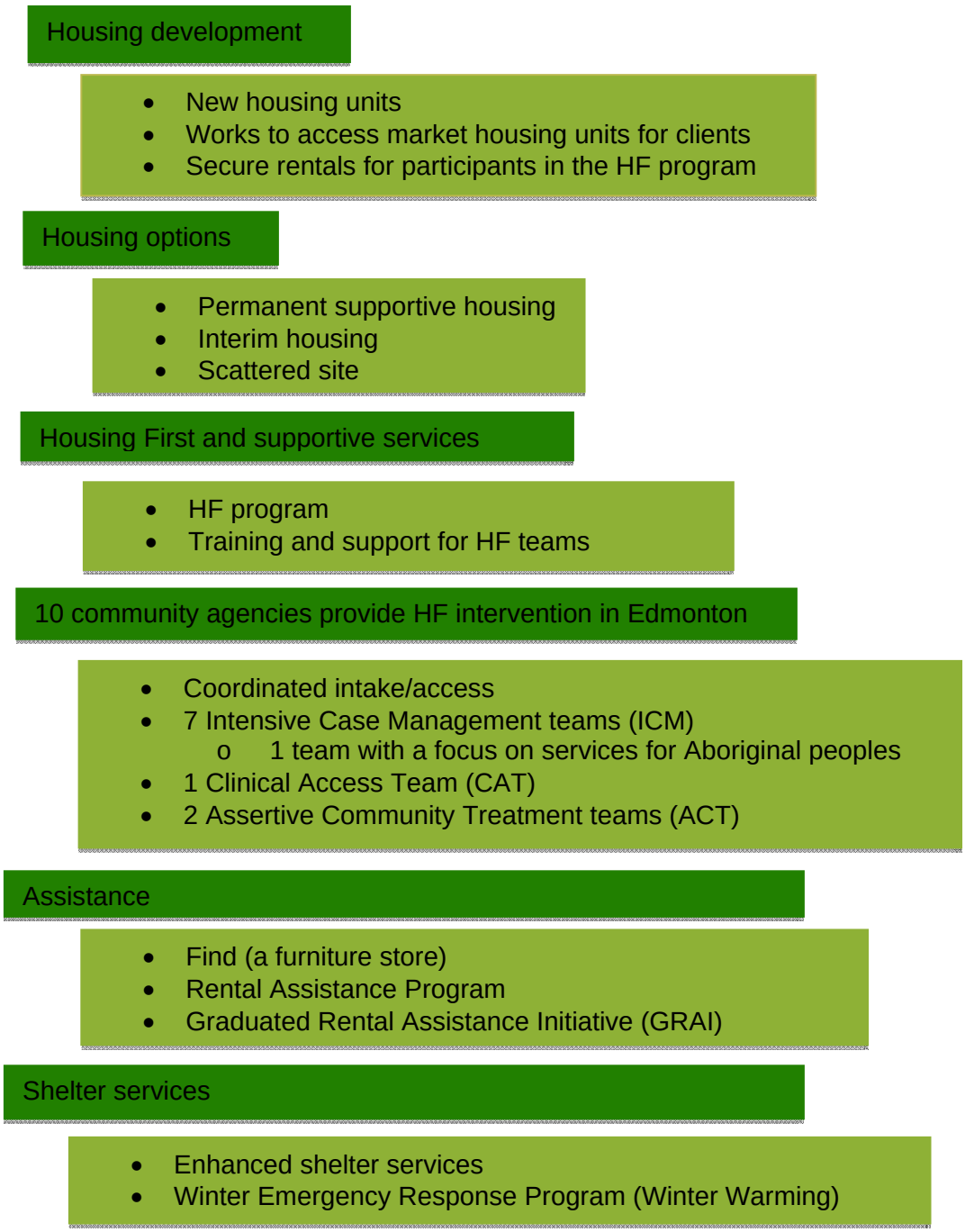



*Figure 2*.Homeward Trust services. The dark green boxes specify the type of service whereas the light green boxes list some examples of the services provided.

*How a Homeless Individual Accesses Housing in Edmonton*[4]

Edmonton uses a decentralized system, or scattered approach to providing HF services. As such, the "no-wrong door" approach is integral for homeless individuals to access services. A client will express an interest in housing to one of the HF agencies (10 agencies have HF programs). The client will be referred to that agency's HF team and will be assigned an intake worker/HF worker. The intake worker will complete the first two SPDAT assessments (at the intake and housing stages) and will search for housing for the client, including advocating on the client's behalf in interviews with landlords. At an interview, the intake worker will bring a letter that explains the program, guarantees funding and damages covered. This letter helps landlords skip the credit check process, which can be a barrier for housing for clients with bad credit.

A number of factors are considered when choosing housing for a client. Depending on the client's acuity, he or she may be directed toward market housing, market housing with mobile supports (CAT; ACT), or more structured supportive housing. A committee and sub-committee at HT review all applications to see if a client needs permanent supportive housing. Decisions are also based oncognitive limitations, client needs, the tenant mix and supports available at the housing location. CP is the first level of supportive housing. At this level, there is an on-site tenancy manager, but no on-site supports available (mobile supports are available). As clients' acuity increases, more on-site supports are added. As more specialized staff are added, the housing model moves away from permanent supportive housing to a more institutional model.

For access to HF housing, clients are expected to take part in the HF program. At CP, clients can come from a number of different HF agencies. There is no waiting list at CP; vacancies are filled based on need/dire circumstances. While most clients who enter HF have been homeless for a specific period of time, recent homeless who have children or are vulnerable in some way can be accepted in the HF program through an SOS referral. In an SOS referral, clients do not need to have a high acuity as it is considered an emergency situation.

Once the intake worker sets the client up in his or her new home (including helping with furnishings and some groceries), the client is transferred over to the follow-up support worker. The follow-up support worker will remain with the client for the duration of the program completing SPDAT assessments regularly every three months. The follow-up support worker will help the client reach his/her goals [getting an ID; going on Assured Income for the Severely Handicapped (AISH); job training, etc.] and become stable before

[4]For more information on any of the services that a homeless individual would access, as listed in figure 2, visit the Canadian Homelessness Research Network's resource file on Homeward Trust Edmonton.

the client is graduated from the program. The worker may help clients re-learn how to live in a home, and attend doctors' appointments to advocate on their behalf, along with a range of other possible activities. While clients are in the program, they have access to the Rental Assistance Program, which will give partial funding towards a client's rent (the other part may be funded by AISH; income support; employment).

Depending on the acuity and the program for the client, the client will be expected to graduate in three months (LihFT –Low Intensity Housing First Team, geared towards rapid rehousing); or after 12 months (HF team) (Gaetz, Scott & Gulliver, 2013). A client will only graduate if s/he has an acuity of less than 25, which indicates that they are more stable in several aspects of their lives (in other words, perhaps they have dealt with or mitigated some of the systematic issues they face in terms of mental health, addictions, education, medical needs, etc.). If the client has graduated and is independent except for the ability to cover the market rent, s/he will enter the Graduated Rental Assistance Initiative (GRAI). Graduation does not include the expectation that clients will move from supportive housing to market housing. Some clients may only be able to reach stability or stay housed successfully in a supportive environment. Graduation also does not require clients to stop using alcohol or drugs, unless they specify that it is one of their program goals.

*Canora Place*

Homeward Trust provides funding for the development of new housing units in Edmonton aimed at decreasing homelessness. Canora Place is a Jasper Place Health and Wellness Centre (JPHAWC) supportive housing project. The Wellness Centre applied to Homeward Trust's RFP for Housing and Homelessness. The province funded 70% of the CP development while HT covered the remaining 30% ensuring that CP could open its doors mortgage-free (Jasper Place Health and Wellness Centre [JPHAWC], n.d-a).Canora Place opened its doors in March 2011, taking 7 months from development to completion. On the ground, the building, in the form of 27 separate cubes went up in five days with the help of a hired crane. The cost of CP, including the land was $5,600,000. Canora Place is a self-sustaining building, which means that after the initial start-up grant, CP operates on the $225,000 a year generated by residents' rents.Canora Place is embedded in the HF program in Edmonton as one of the available housing options (one that can be used, for instance, for clients who have not been able to stay housed in market apartments). Furthermore, CP fits into the HF model by focusing on permanent housing; adopting client-centred practices and using a harm reduction model. While CP is embedded within a larger HF system, it could be stated that, on its own, not all aspects of CP align with a HF philosophy. For example, clients can be rejected if they are under the influence of drugs or alcohol during their intake interview and they can be rejected from housing if they have a history of violence, intolerance or are a registered sex offender (JPHAWC, n.d.-a).

**Building layout.**CP is an apartment building that provides permanent housing to chronically homeless individuals with addictions and/or mental illness. CP a three story apartment building comprised of 30 self-contained units of which 15 are bachelor apartments ($550 a month plus $50 for power), 14 are one-bedrooms ($650 a month for large one-bedroom) and one is a two-bedroom. Of those 30, five apartments are accessible for tenants with physical, mental or sensory disabilities (Homeward Trust Edmonton, n.d.-a; Alberta Safety Codes Council, 2008).Canora Place has a modular design and 24 cameras recording activity in the building 24-7. Canora Place has a mandate to house 50% Aboriginal tenants. Half of the residents are from JPHAWC while others come from other HF agencies. The building design was considered in order to make the building feel less institutional while also blending with the rest of the neighbourhood. Design consultations were conducted with architects as well as former residents.

**Staff.**There are two staff on-site at CP during the day from 9-5 (the residency/building manager and the community support coordinator[5]). Another night-time support/security worker takes over from 4-8pm Monday to Friday and the part-time night staff from 8 pm-2am. Three or four staff are responsible for rotating this nighttime position. No staff are present during the day on the weekends.

**Screening Process, Rejection and Evictions.**Residents must be 18 years old to be housed at CP. There is a two-stage applicant screening process to accessCP housing involving interviews with the landlord. Canora Placeresidents are also screened for eligibility. A verification of homelessness, of physical or mental disabilities, family composition, household income and date of birth may be required. Canora Place must comply with fair housing laws and make reasonable accommodation for residents living with disabilities during the screening process, occupancy, management, maintenance, employment and interactions with tenants. Clients, however, could be rejected from housing or the interview on the basis of being under the influence of drugs or alcohol (the interview is ended ASAP) or making false statements during the interview. Clients could be rejected if they miss two scheduled appointments during the screening process. Finally, they could be rejected if they have a history of violence (towards tenants or landlords; conviction of hate crimes or child abuse); intolerance or are a registered sex offender (JPHAWC,n.d.-a).

Residents can be evicted based on a substantial breach of the lease (attached to the lease are CP rules). Eviction occurs on a case-by-case basis. Residents may be given a 14-day notice after two or three breaches. If violence is involved theresident may be given 24-hour notice and evicted immediately. In such a case, the resident's support

[5]The community support worker at CP had taken a job as a follow-up support worker through HF at the time of the interview, and was transitioning to fewer hours at CP. His time at CP is now focused on community engagement and clients are supported through their own support workers.

worker is informed ahead of time. One of the benefits of the flexible landlord role is that evictions can act as a motivator and after strategizing with the support worker, the resident may be allowed to stay at CP. According to one staff member, CP has had a 19% turn over in the past 2 ½ years due to evictions, deaths and clients' relocation.

**Canora Place Expectations of Drug and Alcohol Use.**Residents are advised not to buy or sell drugs from their apartment or have others use drugs in their apartment. Staff adviseresidents to treat their home as their refuge and place of safety. If residents need to buy drugs, they should exit the neighbourhood to do so. Like any other landlord, CP staff must give 24-hour notice to enter a resident's apartment. If criminal activity is suspected, staff keep a log-book to record that activity and confront the resident about it. The log-book is an important record that can be used in legal proceedings. Staff may also record visits by emergency personnel, other authorities, physical or verbal altercations or maintenance needed. Also logged in the book is the "pulse of the building," which is recorded hourly: staff note the level of activity in the lobby and other parts of the building (JPHAWC, n.d.-b).

### 5.4 Demographic Profile of ICMD Residents

The 11 participants interviewed had lived at CP from a few months to over two years. On average, participants were 55 years old and male (*n*=9). Participants interviewed were Aboriginal (*n*=7) and Caucasian (*n*=4). All residents interviewed were confirmed to be ICMDs; however, participants self-reported specific information on substance abuse and mental illnesses. Canora Placeparticipants drank alcohol (*n*=5; including occasional use, n=8) and used substances. Participants used crack/cocaine (*n*=2), marijuana (*n*=1; including occasional use, *n*=2), and speed (*n*=1). Participants also self-reported their mental health disorders. Most of theparticipants reported experiencing depression (*n*=4), while others experienced PTSD (*n*=1; including suspected PTSD, *n*=2), bipolar (*n*=1), FASD (*n*=1), anxiety disorder (*n*=1) and personality disorder/antisocial (suspected in *n*=1).

Participants also reported experiencing numerous physical health conditions. Some physical conditions mentioned by participants included being legally blind,having had a stroke, heart attack, kidney transplant, and broken bones or nerve damage from minor and major accidents, such as falling or being hit by a car.

### 5.5 Success and Barriers

*Success: Effective Supportive Housing Methods Used at Canora Place*

Canora Placeresidents shared what they liked at CP based on living at CP and elsewhere. Residents liked CP more than any other housing location (*n*=3). Residents described CP as secure housing that felt like home. One resident described CP as luxurious compared to other housing. At CP, residents said they were able to cultivate a

sense of friendship and community in the building while retaining their sense of independence and normality, dignity and respect. Tolerance and a sense of belonging coupled with friendly staff also helped residents feel at home. One resident admired CP's cleanliness and efficiency. Another liked the possibility of remuneration through JPHAWC's redemptive development program.

Residents recognized that CP might be their last housing option as many could not be housed elsewhere. Those residents liked being given a second chance at a quality life and the positive support. Residents liked the flexibility and understanding of renting with CP, as well as it being 20% less expensive than market rent. Two residents mentioned how CP helped with their rent: when one went to jail and when a clerical error was made on income taxes for another. One resident liked being helped with addictions and another was thankful that CP would not deny housing to clients struggling with alcohol or addictions.

Staff and stakeholders also shared their perspective on what is working in Edmonton and CP. The following are the main themes from their interviews.

**Using services already in place.** Staff and stakeholders commented on what works in the Edmonton context. The ability to build on structures that were already in place in the city, including making use of the services and structures offered by wellness centers and other services was noted. The ability to make use of the systems and services already in place is one of the hallmarks of Edmonton's decentralized system. Clients are encouraged to use the services available to all Albertans, with a focus on using them in a responsible way to decrease emergency service usage.

**Environmental controls/rules.** Particular to CP, staff noticed that the environmental controls for residents with higher acuity were particularly effective. Staff suggested that this is because mental illness increases acuity more than addictions. Having an environmental control is effective for individuals who have difficulty controlling their environment on their own. Staff noted thatresidents in the 45-50 acuity range tend to do well at CP.

**Compassionate tenancy manager.** Canora Place's compassionate tenancy manager helps prevent residents' evictions, by allowing some flexibility with the resident, where in market housing certain behaviour would result in immediate eviction. CP functions as a landlord, but also a sister agency to many HF teams, which makes it easier for support workers to advocate on behalf of CPresidents.

**Support worker/community advocate role.** The support worker/ community advocate role at CP helps build connections between the community and the building and also supports other HF staff with their clients at CP. The CP community advocate can foster connections between the community and residents to help residents integrate into

the community and increase community acceptance of the building, as well as to slowly change the community's perceptions of mental illness. Examples of community connections fostered by this role are residents cleaning up the park, the lawn or delivering flyers. As noted by the support worker, the foundation of a good community relationship is when CP's words equal its actions. Building a relationship with the police is also an important part of CP community engagement. When the police are impressed with the building and conflict management at CP they can communicate this information to community members to dispel their perceptions of the building.

**Building strategy.** Building CP off-site was a strategy that made the building process less antagonistic to neighbours, contributed to efficiencies around purchasing, improved labour costs and boasted a smaller environmental footprint. By being constructed in a plant, work-place safety was also increased. The modular design allowed the building to be constructed quickly so that doors could open sooner. It assisted, furthermore, with the sound proofing necessary for the comfort of residents whose neighbours may operate on a different sleep schedule.

**Self-sufficient.**Canora Place operates on residents' rents. A key to CP's success is providing affordable, permanent, supportive housing.

**Staff with education and training.**Homeward Trust seeks out staff with education and training who are specialized to work with the vulnerable population and who are good at building relationships (very important as much of what they do is broker connections). Staff who are educated can also bring a macro focus to their individual cases in order to understand the resident in the context of the larger social problem.

**Positive resident environment.**Canora Place provides housing to hard-to-house individuals and accepts clients where they are. Canora Place is based on harm reduction, where residents are allowed to use as long as they do not infringe on other residents' rights. Meaningful daily activity is found through redemptive development and outings, as well as other organized activities offered through JPHAWC which is situated less than one block away from CP. Finally, the CP community support worker sometimes provides transportation, or chats over coffee or lunch off-site. Other CP staff always keep their door open, remaining available for a chat or a card game on-site.

*Housing First is Effective*

From 2008-2012, there has been a 30% decrease in homelessness in Edmonton. In the 2010 HT report, they noted that 1000 people were housed in 20 months (Homeward Trust, 2010). In 2012, 773 homeless individuals were housed, 76% of which were deemed chronically homeless at intake (Homeward Trust, 2012a).

*Challenges and Barriers*

Residents also reported some aspects of CP that they did not like. For example, residents did not like the rules, especially those regarding visitation. At CP, residents are allowed guests after 3 months with permission (3 overnight visits per month are allowed) otherwise guests should leave after 11. When guests of tenants are intoxicated, visits are denied, as the tenant is not capable of being responsible for his/her guest (JPHAWC, n.d.-b). One resident felt the 11 o'clock rule encouraged guests to drink and drive. Residents also recognized how the rules could contribute to their security, however. Residents who had challenges maintaining their housing in the past due to sneaking homeless individuals into their housing were not able to with the security at CP. One client specifically mentioned liking the structures provided by CP. Some residents were unhappy with CP's location as it was far from family; they were not from this part of town and/or they did not feel it was safe in the area. Some residents noted that they felt it was good they were away from the bad influence of friends/acquaintances living in other communities. Other residents commented on the noise levels, the heat in the summer, an uncomfortable bed or the ability for strangers to peek in the windows on the ground floor. One sober resident disliked being around other residents who used, especially when they came to his door to ask for money. He spoke of the possibility of leaving CP in the future.

Of course, there are also some difficulties present in the Edmonton system.Staff and stakeholder interviews identified some of these difficulties that are summarized below.

**Falling through the cracks.** Two homeless populations fall through the cracks of the HF program: the new homeless and extreme chronic homeless. In order to access HF, clients have to be homeless (including couch surfing) for one year of chronic homelessness or have had four episodes of homelessness in three years. The extreme chronic homeless, on the other hand, are considered an entirely different demographic. Many live on the city's parkland, have extensive needs and are not connected to the services available (e.g., shelters, soup kitchens).

**HF limits.** Housing First is a good start, but it still does not cover issues of food security, transportation, employment needs or mental health beyond stabilization.

**Building design.** Specific to CP, the number of units in the building does not provide enough rent to support 24-hours of support. As for the development of the building, the architect's design of kitchen islands in the apartments turned out to be wasted space as islands are not popular amongst the target population.

**SPDAT variability.** Support workers rely on "experiential data" as well as the SPDAT, as results can vary depending on the assessor.

**Housing availability and variety.** As always, more housing is needed for individuals with complex needs, as well as more housing in general. Complex needs clients

can find themselves without housing if they are dependent on supports and using (CP requires independence, and many homecare nurses will not deal with addictions). As there is low vacancy in the city, HF is at capacity. As such, instead of trying to find the best place, the focus turns to finding *a* place for clients. It is important to find the right housing for each individual's needs as a harm-reduction building can make it difficult for recovering clients to stay sober. Furthermore, due to constant rent increases it can be difficult for clients to maintain housing once the program has housed them.

**Staffing issues.** While HF staff are paid above average and have a higher retention rate, there is still staff turn-over because it is intensive work. Follow-up support workers have a caseload of between 17 and 20 clients depending on their experience and capacity. Furthermore, when recruiting it can be difficult to find people with the right skill and compassion. At CP particularly, one staff member noted that the organization could benefit from someone trained in suicide intervention (night time staff are not trained in the area). She also noted that an addictions counsellor could be useful to clients if the service is easily accessible. Client information is provided on a need to know basis. As such, workers who spend the most time with clients may not be aware that some clients can be dangerous under certain circumstances..

**Resident challenges at Canora Place.** There can be conflicts between residents due to their mental health. Similarly, in a client-centered model, it can be difficult to work with residents on their mental health or addictions issues if the resident does not acknowledge them. Another challenge for residents is that there are no programs on-site and no community kitchen at CP.

## 6.0 McEwen Manor (Regina): Process Results

The following section describes the process evaluation conducted at McEwen Manor (MM)in Regina, Saskatchewan.

### 6.1 Methods

*Key Stakeholders/Staff*

Interviews were conducted with two staff who oversee MM and one staff member who works at MM. In addition, two stakeholder interviews were completed with representatives from Ranch Ehrlo, a multi-service society that provides residential, clinical, community and educational programs across the province, and Regina Qu'Appelle Mental Health Clinic, respectively (Ranch Ehrlo Society, n.d.).Four of the five interviewees had 20 or more years of experience with their organization, while one had just over two years of experience.

*McEwen Manor Residents*

Interviews also were conducted with 12 residents living at MM who were identified by staff as being ICMDs. Information obtained from the resident (client) interviews was supplemented by a case file review. All residents consented to the case file review. Data were collected during July 2013.

*Document Review*

Information from the staff and stakeholder interviews was supplemented by a document analysis, including an analysis of program documents and policies, case file templates, staff meeting minutes, tenant meeting minutes, the 2012-2013 annual report, presentations about the program, and promotional materials.

### 6.2 Program Description

Phoenix Residential Society was established in1977. It originally started as a group home and has expanded over the past 37 years to include seven programs, including MM. All Phoenix Residential Society programs are grounded strongly in the philosophies and evidence pertaining to:

- Psychosocial rehabilitation (also sometimes referred to as psychiatric rehabilitation and is focused on empowerment, quality of life, community integration, personal support networks, health and wellness, hope and respect, as well as on being strengths-based, person-centred, culturally relevant, and evidence-based; Phoenix Residential Society, 2013);
- Recovery (from additions, mental health, and health issues);
- Choice theory and reality therapy (which focuses on helping individuals function effectively despite their illness and symptoms of illness); and
- Harm reduction.

Ultimately, Phoenix Residential Society strives to help individuals live as independently as possible and have meaning and purpose in their lives. At MM, in particular, the program aims to provide residents with a place to live that will feel like home and where they can be accepted, safe, secure, and experience a sense of community.

Phoenix Residential Society first became interested in building a supportive housing residence when it became clear that the building which held their previous treatment program intended to serve ICMDs (i.e., the Westview Dual Diagnosis) required renovation and the lease to Phoenix's own office space was ending. McEwen Manor was perceived as a way to expand Phoenix's services for ICMDs (Westview only treated 10 clients) and provide the required office space.

Several partners were involved in the development of MM; however, the primary partnership driving the initiative was one between Phoenix Residential Society and Ranch Ehrlo. Ranch Ehrlo approached Phoenix about their interest in building a supportive housing residence together, as it is part of Ranch Ehrlo's mandate to partner with other organizations to further their aims of housing disadvantaged groups in the community. In this partnership, Ranch Ehrlo was the expert on the housing development process and understood all of the elements inherent to this process. Conversely, Phoenix was the expert on the types of support services that would be required by residents and could inform the development process in that capacity. Ultimately, it was decided that Ranch Ehrlo would be the landlord to the residents of MM and Phoenix Residential Society, while Phoenix would provide the necessary supports to residents. A number of additional partners also were involved in the development of MM. The partners and their contributions to the development of MM are listed in Table 1. The total cost of building MM was $6,085,000 which amounts to approximately $150,000 per door (40 suites). Ranch Ehrlo holds a mortgage for MM in the amount of $413,000 that is paid by rents obtained from residents and the commercial office space. Ongoing support to facilitate the operation of MM continues to be provided by the Regina Qu'Appelle Health Region, Ministry of Health, Acquired Brain Injury Program (which is funded by the Ministry of Health and Saskatchewan Government Insurance [SGI]). It costs Phoenix $45/day or $18,000/year to house a single client in MM; annual operating costs are $467,000/year. Table 1 outlines additional funding provided by MM's partners.

Table 1: *Partners and Contributions for the Development of McEwen Manor*

| Partner | Contribution |
|---|---|
| **Saskatchewan Housing Corporation** | $3,072,000 |
| **City of Regina** | $400,000 |
| **Homeless Partnering Strategy** | $800,000 |
| **Saskatchewan Ministry of Social Services – Community Living Division** | $800,000 and contract staff services |
| **Schizophrenia Society of Saskatchewan – Regina Chapter** | $100,000 (for furniture and equipment specific to resident needs) |
| **Ehrlo Community Services** | $413,000 (mortgage); $100,000 (cash); and $400,000 (land purchased) |
| **Regina Qu'Appelle Health Region** | Staff Resources |

McEwen Manor is one of the seven programs operated by Phoenix Residential Society (i.e., Phoenix). It is a long-term supportive housing residence for individuals with mental health disorders, problematic substance use and/or alcohol use, and cognitive disabilities. McEwen Manor's apartment-based residence opened in 2012 in response to evidence suggesting that group homes are not as effective for helping ICMDs with their recovery as other forms of housing. At MM, residents receive high to moderate levels of support including services pertaining to daily living, medication management and financial trusteeship, and addiction recovery services. McEwen Manor residents are expected to abstain from alcohol and drugs.

McEwen Manor is comprised of 40 units: 30 suites for residents with mental health and addictions, 8 suites for residents with cognitive disabilities, 1 respite suite, and 1 suite designated as an office space for staff. All suites are bachelor style units ranging from 283-404 square feet and come fully furnished with a small fridge, a two-plate glass cooktop stove, bed, dresser, television, and chair. Four suites are wheelchair accessible. Rent is $725.00 per month (30% of a resident's income) and includes utilities, insurance, basic cable, five loads of laundry, and Wi-Fi (depending on proximity to the modem). Most residents receive some form of assistance, such as Saskatchewan Assistance Program, Saskatchewan Assured Income for Disability, and/or Saskatchewan Rental Housing Supplement. Apartments are located on the second and third floors of the building, while the main floor of MM is zoned as commercial business space; it hosts a Laundromat operated by the Canadian Mental Health Association – Regina Branch and the main office spaces of Phoenix Residential Society and Ranch Ehrlo. Within Phoenix's space, there is a large multi-purpose room with a kitchen area, dining area, sitting area, computers, and television to accommodate group programming for residents of MM.

Mental health suite residents are referred through the Regina Qu'Appelle Mental Health Clinic The Saskatchewan Ministry of Social Services' Community Living Division refers residents living in the cognitive disabilities suites, and some residents are transferred to MM from other Phoenix programs. A referral package must be completed for each applicant including an application, community support plan, and psychiatric assessment. An Admission Committee that includes the manager and residential coordinator of the Regina Qu'Appelle Mental Health Clinic and three staff from Phoenix Residential Society meet every month to review applications and decide who will be offered any available spaces. If no spaces are available, applicants for the next available space are prioritized. The committee focuses on selecting residents who are in highest need and who would benefit the most from living at MM. As of July 2013, there were 15 to 17 individuals on the waitlist for MM. Since the residence opened in January 2012, there has been minimal turnover with only two residents leaving the residence. Since the waiting time for the program is a matter of years, program staff suspected that the waitlist would be longer if there was a greater likelihood that residents on the waiting list may actually have a chance of getting a suite.

Upon intake, clients sign a lease and a statement of residency expectations, and complete a move-in checklist, Phoenix Residential Society Trustee Agreement, resident data sheet, authorization for release of information, cooking questionnaire, and various assessments designed to determine their level of need and severity of their mental health and addictions issues. The assessments employed include the: Camberwell Assessment of Need (Phelan et al., 1995), Multnomah Community Ability Scale (Barker, Barron, McFarland, & Bigelow, 1994), Drug Use Scale (Mueser, Noordsy, Drake & Fox, 2003), Alcohol Use Scale (Mueser et al., 2003), Stages of Change Readiness and Treatment Eagerness Scale (Miller &Tonigan, 1996), and the Substance Abuse Treatment Scale (Mueser et al., 2003). After entering the program, charts are kept for each resident and the following information is tracked: client information; referral information, move, and trustee forms; contact notes; medication/medical information; hospitalizations and other key information; program plans/progress reports; finances and budget sheets; receipt envelopes; and move forms.

McEwen Manor residents have 24-hour supports. Residents are checked on at least once every 24 hours and weekly apartment checks are conducted. Staff will enter a resident's apartment, after knocking, without his/her permission in the following circumstances: a) to call residents for their medication or appointments or programming related to their service plan; b) if there are concerns about damage to the apartment (e.g., fire, flooding, odours); c) if the resident has not been seen for 24 hours and his/her whereabouts are unknown; and d) if there are concerns regarding the physical and/or mental health of the resident.

A range of programming is offered at MM. Attendance is optional for all programs except for medication management and financial trusteeship. The programming that is offered is shaped by resident input and focuses on the issues with which residents are struggling. However, the programming offered has generally not been well attended; recreational activities tend to be better attended. The resources, activities, and services available to residents include the following:

- Medication management (i.e., at first, medication is provided to residents in pre-determined amounts as prescribed; if residents miss their medication, staff will remind residents; as residents gain independence, they may gain responsibility for their medication for the week).
- Financial trusteeship (i.e., Phoenix acts as the resident's financial trustee; staff help residents develop budgets and manage their money; as residents demonstrate good money management behaviours, they may gain independence over their finances)
- Access to addiction recovery services (residents are expected to be involved in recovery groups if actively using; e.g., Alcoholics Anonymous, wellness group)
- Leisure/social/recreational activities (e.g., sports, bowling, swimming, going to the gym, pizza nights, baking groups, movie and popcorn nights)

- Assistance with skills of daily living (i.e., laundry, apartment maintenance, hygiene, grocery shopping)
- Access to life skills
- Assistance with attendance at appointments (i.e., doctor, probation)
- Assistance with clothing/hygiene issues
- Assistance with accessing medical services
- Family contact/support
- Crisis intervention/resolution of interpersonal conflicts (a clients' case managers at the Regina Qu'Appelle Mental Health Clinic are involved when he or she shows signs of struggling with their addictions or mental health issues)
- Support/help regarding criminal justice system

Medication management and financial trusteeship reflect perhaps the most critical services offered by MM. It should be noted that participation in some activities is earned through participation in programming. Residents may also earn additional income by doing work around MM (e.g., shovelling the snow).

Residents are able to stay at MM for as long as it is helpful to them and for however long they wish to stay. Tenancy in the program is voluntary; although, there are some residents who are on court treatment orders to live there. If clients do leave, MM develops a discharge plan to ensure they will not be homeless upon leaving.

McEwen Manor does not operate using a formalized HF model, but instead adheres to the practice of housing first (little h, little f[6]). In addition to focusing on immediate access to permanent housing, MM also adopts a recovery orientation and a harm reduction approach. McEwen manor staff are guided by a person-centred, strengths-based philosophy and are focused on community integration and client empowerment. A variety of optional activities are also offered at the residence. However, there are aspects of MM that are not consistent with a HF approach such as mandatory medication management and financial trusteeship and expectations to abstain from drugs and alcohol.

*Staffing*

McEwen Manor consists of an Executive Director (of Phoenix Residential Society), a Program Manager (who also manages two other Phoenix programs), an Education Practice Consultant (who works with all staff at Phoenix), two full-time key workers who work directly at MM between 8:00am to 11:00pm, one full-time night staff, up to 4 support

[6] "Little h, little f" refers to adopting housing first (hf) as a *practice* (being housed instead of having to fulfil other requirements first). Housing First (HF), on the other hand, refers to adopting the HF *program* and adhering to core principles of the HF model.

workers, and approximately 11part-time or causal psychosocial rehabilitation workers. There is always 24 hour on call coverage. Key workers have a caseload of 15 clients each.

Staff members have a variety of backgrounds (e.g., nursing, psychiatric nursing, social work). Phoenix primarily strives to hire staff who will be a good fit for the organization, such as having a person-centred approach, being able to appreciate ambiguity, and being flexible and accommodating (but not laissez faire). Phoenix is not able to offer a competitive wage to staff in comparison to what they may earn outside of the not-for-profit sector, but compensate by offering staff as many training opportunities aspossible. In fact, Phoenix has an Evaluation and Assessment Review Committee that oversees the professionalism of Phoenix Residential Society and its staff training needs.

*Evaluation and Planning*

The Board of Directors overseeing Phoenix Residential Society follows a three-year plan. At the time of this study, Phoenix was in the midst of its own internal review process to understand how well MM was implemented by taking into account the perspectives of staff, residents, family members, and stakeholders. As an organization, Phoenix frequently engages in self-evaluation about what they are doing, why they are doing it, and whether something else should be done instead. They also have recently developed a database to track client outcomes and use this information to subsequently inform their programming

### 6.3 Demographic Profile of ICMD Residents

The following table (Table 2) outlines the demographic profile of the residents who were interviewed.

Table 2: *Participant Characteristics*

| Category | Resident Characteristic |
|---|---|
| **Number of residents interviewed** | 12 |
| **Mean age** | 34 years |
| **Gender** | Male (*n*=9) |
| **Ethnicity** | Aboriginal (*n*=6); Caucasian (*n*=6) |
| **Substance or dependence disorder (diagnosed, suspected by staff or self-reported)** | Substance or dependence disorder (*n*=12)<br>• Alcohol abuse or dependence disorder (*n*=10) |
| **Mental health disorder (diagnosed, suspected by staff or self-reported)** | Mental health disorder (*n*=12)<br>• Schizophrenia (*n*=8)<br>• Schizoaffective/psychotic disorders (*n*=4)<br>• Depression (*n*=4)<br>• Anxiety disorders (*n*=2)<br>• Borderline intellectual functioning (*n*=2) |
| **Physical health conditions** | One or more physical health conditions (*n*=8)<br>• High cholesterol (*n*=4)<br>• Hospitalization during residency at MM (*n*=3)<br>• Acid reflux (*n*=2)<br>• Obesity (*n*=1)<br>• Diabetes (*n*=1)<br>• Low thyroid functioning (*n*=1)<br>• Hepatitis C (*n*=1)<br>• Asthma (*n*=1)<br>• Arthritis (*n*=1) |

All participants had lived at MM for much of the time it had been open, with their length of stays ranging from 15 to 19 months (as of July 2013). Nine participants were referred to MM by the Regina Qu'Appelle Mental Health clinic, while three participants were transferred to MM from other Phoenix programs. Two participants were court-ordered to live at MM and also had court-orders to take their medication. Participants had varying levels of education from grade 8 or lower to some post-secondary education (i.e., college or university courses). Two participants were employed; one full-time, and one part-time.

According to the most recent Multnomah Community Ability Scale[7] assessment completed with participants as of July 31, 2013, five participantswere classified as"moderate" functioning (48-62), and seven were classified as"high" functioning (>62); no participants were assessed to be "low" functioning (<48). Case files provided information

[7] A scale assessing the extent to which clients are able to live independently.

about the participants' life skills, budgeting skills, health and safety behaviours, and interpersonal skills and relationships. Table 3outlines participants' skills with regards to these four areas.

Table 3: *McEwenManor Participant Information*

| Participants' skills/ areas of functioning | Participants' abilities |
|---|---|
| **Life skills/daily activities** | • Difficulty keeping their homes clean (*n*=4)<br>• Needed assistance with grocery shopping (*n*=4)<br>• Difficulty eating healthily (*n*=3)<br>• Difficulty maintaining personal hygiene (*n*=2)<br>• Poor cooking skills (*n*=1).<br>o residents deemed to be adequate and/or independent in these five areas (*n*=5)<br>• Not engaged in daily meaningful activities (*n*=4)<br>• Engaged in meaningful activities such as hobbies and employment (*n*=2).<br>• Did not participate in MM programming (*n*=2)<br>• Participated regularly in programming (*n*=3) |
| **Budgeting skills** | • Difficulty budgeting (*n*=6)<br>• Needed help creating a budget but able to follow a budget (*n*=4)<br>• Able to budget their own money (*n*=2). |
| **Health and safety behaviours** | • Regularly experienced uncontrolled symptoms related to their mental health disorder(s) (*n*=4)<br>• Regularly took their medications (*n*=7)<br>• Frequently missed their medications (*n*=4)<br>• Did not believe they had the mental disorder with which they had been diagnosed (*n*=2).<br>• Considered to be quite stable (*n*=5).<br>• Engaged in alcohol or substance abuse<br>o Ongoing (*n*=3)<br>o Occasional (*n*=3)<br>• Did not think their alcohol or substance use was problematic or had an impact on their mental health (*n*=4).<br>• Sober for 18 months or more (*n*=4)<br>• Sober for substantial portions of their residency at MM (*n*=2). |
| **Interpersonal relationships** | • Weak communication skills or relationships (*n*=5)<br>• Meaningful communications and relationships (*n*=5) |

## 6.4 Success and Barriers

*Success: Strategies that Facilitated the Development of McEwen Manor*

In the staff and stakeholder interviews, a number of aspects of the development process were highlighted as facilitating the building of MM.

**Partnerships.** One of the strengths of the development process employed in building of MM was centred around partnerships. Specifically, having a primary partnership which included an organization that was an expert in the housing development process (i.e., who understood “the bricks or mortar” component of the housing development process; Ranch Ehrlo) and one that was an expert in the clients’ needs and types of supports (Phoenix Residential Society, 2013) contributed to the success of the housing development process. In fact, this type of partnership was attributed as helping the project team navigate hurtles quite efficiently to complete the project in a relatively short timeframe compared to similar projects. Further, in developing MM, Phoenix Residential Society strove to partner with organizations that had similar mandates, missions, values, and principles which made it easier to work towards a shared vision. In addition, partnering with various levels of government and community-based organizations helped Phoenix and Ranch Ehrlo require the necessary funds to build MM and further served to ensure that the needs of clients would be met in the new residence.

**Business plan.** Having a strong business plan was another factor that facilitated the development of MM. In particular, Ranch Ehrlosociety employees led the development of the business plan and went through great efforts to ensure that the business plan was adhered to in order to ensure the sustainability and utility of the housing project upon its completion. Specifically, a formula was used to determine the number and size of suites that should be built according to the number of units that could be rented at an affordable price based on Social Services rates. It was determined that MM should have 40 suites; however, there was pressure placed on the project team to build only 32 suites. The project team resisted this pressure and insisted they would only go ahead if they could build 40 suites to ensure affordability. Similarly, there was resistance from some partners to allocate funds for an elevator. However, Phoenix knew its residents may have physical disabilities and that accessibility would be an issue for some residents. Phoenix also foresaw that its clients would be more likely to have compromised health conditions where emergency services may be required to respond and potentially carry a client down with a gurney. Again, Ranch Ehrlo and Phoenix insisted they would not move ahead with the project until an elevator was approved; this approval was eventually granted.

**Incorporating design principles with clients’ needs in mind.** Another strategy employed in developing MM to ensure the suitability of the residence for its anticipated clientele was to incorporate design principles that would make the building feel like an apartment building rather than an institution, foster an environment of safety, and help

keep the building in good condition (e.g., modern colours and lighting). The durability of the building was enhanced by placing plywood behind the gyprock, incorporating built-in furniture, and providing residents with the basic furniture and appliances they required. In the suites, only two-plate glass cooktop stoves were installed since it is not possible to 'hot knife' on these types of stoves and the residents generally did not use ovens. Further, suites were purposefully not placed on the main floor to avoid people coming in off the street and onto the residential floors. In addition, security buzzers were directed to the main desk to allow staff to monitor who was entering the building and whether they were legitimate visitors. Finally, aside from the two outdoor patios, common areas were purposefully not located on the residential floors to reduce the likelihood for disturbances.

**Being a good neighbour.** McEwen Manor selected its particular location because it was relatively central and close to the mental health clinic, hospital, and many of the social activities and services residents might find important. However, during the development process, MM faced resistance from local neighbourhood residents and businesses who did not want their "clientele" living next door to them. McEwen Manor overcame this resistance by unofficially taking a "good neighbour policy" and being as helpful and accommodating as possible in response to the requests and opposition they were facing.

*Challenges and Barriers*

In general, MM seemed to be functioning quite effectively; however, a few ongoing challenges and barriers were identified.

**Transition to housing program.**Perhaps the biggest challenge with which the program was struggling was the transition from the previous iteration of the program (i.e., a treatment program for ICMDs) to its current form (i.e., a housing program for ICMDs). In particular, staff found that they could no longer use the same consequences if a residentbroke the rules (e.g., brief suspension from the program) due to the lease agreement that was in place which made it illegal to ask residents to temporarily leave their apartments. Related to the issue of suitable consequences, the program was also struggling with the question of: "Where is the line for eviction?" knowing that it wanted to be lenient with residents, but also recognizing that there may be a point where they can no longer be tolerant of the client and his/her behaviour.

**Programming.**Some challenges were also encountered related to programming. Specifically, the amount of funding available to MM was perceived to limit the amount and type of programming that could be offered. In addition, there was low residents attendance at most group programming. Staff perceived that residents were "programmed out" and stopped offering some of their group programming as a result.

**Staffing.**Other ongoing challenges faced by MM were staffing and staff turnover. In particular, it was difficult to attract and retain staff when it was not possible to offer

competitive wages. The organization also found it difficult at times to find staff with the "right" personality or philosophy of client care.

**Rules.**As mentioned in the previous section, only two residents did not like living at MM. These two residents found it difficult to follow the rules that were in place (e.g., curfew, not using drugs or alcohol, abiding by the terms of the trusteeship). One of these residents also felt as if he was being judged by non-residents as being mentally challenged because of the residents who lived in the Community Living suites. The other resident disliked that she was not able to bring her children over for a sleepover[8]. Further, MM staff and stakeholders identified two tensions related to MM's status as a long-term supportive housing residence, namely, permanent housing and long waitlists.

**Permanent housing.**Staff and stakeholders did not want MM to be the end goal for their residents and ultimately would like them to become integrated in the community. However, they recognized that their clients may be successful at MM*because* of the supports they receive and that they would not be able to achieve the same level of independence and success if they were living on their own in the community.

**Long waitlists.**Long waitlists and low client turnover at MM indicated that there was a need for housing of this nature and that there were more clients in need than suitable and available supportive housing options.

## 7.0 Summary of Key Findings and Lessons Learned

Several key findings and lessons learned about housing ICMDs appeared consistently across sites. The following recommendations for implementing HF programs were derived from the examination of the Vancouver, Edmonton and Regina sites and center around the development of supportive housing residences, the implementation of HF and sustaining HF.

*Supportive Congregate Housing for ICMDs is Effective*

Not only did the HF program in Edmonton show a decrease in homelessness and house 1000 people (many of whom were chronically homeless) in 20 months (Homeward Trust, 2010; 2012a), but the three congregate residences also showed positive outcomes. Very few clients left the residences after entering. Since opening, only 19% of residents at

[8]Other than the rules, a pattern of dislikes did not emerge and any dislikes that were mentioned largely reflected individual personalities and preferences. Of these concerns, a desire for a bigger stove, a freezer, and the challenges that may occur when living with people with active addictions (e.g., yelling and screaming in the hallways, feeling judged by non-residents as being mentally challenged because of the residents who lived in the Community Living suites, smelling marijuana on people or in the building, pee in the elevators, being tempted to use) are worth noting.

CP (including deaths) and only 5% of residents at MM were discharged. Although 30% of residents were discharged from PCA since it opened in 2011, 17.7% of the total number of tenancies was considered unsuccessful due to evictions. In addition, the outcome evaluation conducted at PCA revealed that of the residents who were discharged from PCA, they were discharged to more stable living conditions than those discharged from the Triage homeless shelter. Overall, interviews with ICMD residents at the congregate sites found that they were satisfied with the residence and generally felt safe and secure; however, some consistent complaints were regarding drug use and guest policies.

*Developing supportive housing residences*

The residences examined were congregate, supportive housing programs for ICMDsas this type of housing was appropriate for the ICMD populations they housed. In these residences, 24-hour support that could be provided in-house and/or by ACT and ICM teams was deemed important and desirable.All three housing units opened within the last three years and offered lessons learned about building long-term supportive housing residences. For instance, funding from federal, provincial, and municipal governments and non-profit organizations is often required to build supportive housing. A strong business plan, furthermore, is an asset by ensuring the building will be able to sustain itself, as is having an appropriate size for the amount of support and staff available.Partners with expertise in housing development working together with those who are experts in support services can facilitate the development process.

It is important to focus on community engagement during the development phase of a residence especially when community members may be supportive of housing developments for homeless individuals, but not in their own backyard (NIMBY[9]). Having an independent designated communications specialist, instead of the service provider, to communicate with the community can aid in maintaining a smooth consultation process. Consulting with the community in advance, if not from the beginning, before decisions are made regarding the building, is a good practice for establishing positive relations with the community. For communities concerned with too much social housing, developing more scattered site housing may be a preferred option. Finally, it is important to be a good neighbour in the face of resistance, which can mean, among other things, addressing communities' concerns quickly and effectively.

When developing long-term supportive housing residences, they should be specifically designed to meet the needs of ICMDs. This means incorporating physical design features to make the residence feel like a home, increasing the safety and security of the residence, and enhancing the durability of the building. Also, the types of appliances included in units and the layout of units should match the residents' needs. A key

[9]NIMBY: Not in my backyard

consideration is having a separate floor or area of the building for ICMDs who are not currently abusing drugs or alcohol and prefer living in an environment of abstinence. Finally, it is important to ensure that the building contain services/supports and access to resources.

*Implementing Housing First*

All three sites offered insight for implementing HF. Following HF guidelinesby placing an emphasis on housing first, and treatment and services second is important. An important aspect of planning or strengthening the implementation is by making use of the *Corporation for Supportive Housing* resources on quality supportive housing. Evidence-based practices should also be used to provide support services to ICMDs.

Establishing decentralized access to housing is an important aspect of implementing HF. In order for a decentralized system to function, it is important to develop and implement a structured and consistent method of housing the homeless. Edmonton, for instance, adopted the “no wrong door” approach where homeless individuals can access the HF system with the help of any service provider. In many sites, including Vancouver and Edmonton, no waitlist was utilized (although one does exist in Vancouver). At these sites, an individualized and personal method of program entry was used to ensure the best fit between client and residence. It is also important to ensure that other agencies in the city are aware that a supportive housing building will accept all high risk/need clients so that no one is turned away.

The ability to choose appropriate housing for oneself is an important aspect of the HF program. For clients to have choice it means that they need to have options available in the program, such as: congregate versus scattered site as well as housing options based on their needs and the intensity of their needs. Tailoring programming to meet the needs of ICMD clients is also an important aspect of implementing HF. This may include, for instance, structured support in the form of financial trusteeship or medication management. Tailoring programming could also mean a focus on recovery and developing better life skills, opportunities to participate in meaningful activities and socialize with others. Having empathetic landlords is another beneficial aspect of the HF program, because having some flexibility with a landlord helps ensure that clients are able to keep their housing. It is also important to devote extra attention to clients during their first 3 months in the residence to help them transition to their new home. Rules need to be reinforced during the first 90 days.

One final component of implementing HF is bringing together experts and making links to institutions through the use of multi-disciplinary teams. For instance, PCA has community mental health workers, links with medical professionals, pharmacies, and mental health teams. In Edmonton, support workers act as brokers to connect clients to the

resources available in their local community. Building connections within the community is another component of implementing HF, which can be done by:

- Training staff to know what supports are available in the community
- Utilizing outreach workers (who will help make links between clients and supports available in the community)
- Helping clients access existing supports in the community
- Linking clients to doctors, psychiatrists, counsellors, and other health professionals, including those who provide ‘house calls’
- Focusing on developing more connections with independent housing or landlords who will take clients who move on after recovery

*Sustaining Housing First*

After HF is implemented, structures need to be in place to sustain the program. Based on the results of the three sites, one of the key components of program sustainability is the consideration of staff training and staff-related concerns. More specifically, an important aspect of sustaining HF is creating a supportive environment by hiring staff with person-centred philosophieswho are comfortable with ambiguity, and able to be flexible and accommodating. Staff should be trained to provide individualized case management. Training can also be used for staff as a means of compensating for non-competitive wages and ensuring adherence to evidence-based practices. Joint training opportunities can reduce costs and promote the dissemination of shared messages. For instance, PCA participates in joint training with other CMH housing agencies that involves speakers from hospitals, community programs, and police departments and more. Staff training is also promoted in Edmonton and Regina. McEwen Manor, in particular, has an educational consultant that it can use for training purposes.

Some staff concerns, as highlighted at CP and PCA, included the question, “Who has access to client files?”. One of the recommendations that came out of these sites was to allow outreach workers access to client files. Outreach workers at PCA can see client files, get to know doctors and others involved in helping the client; at sites where this was not possible, staff felt disadvantaged. At CP, one of the individuals who had the most contact with clients was unable to see their files, and had placed himself in potentially dangerous situations with one client as a result. When considering who has access to client files, it is important to balance the protection of clients’ information with concerns about the safety and ability of service providers to do their jobs.

An important element of all phases of HF is incorporating mechanisms to evaluate and monitor HF programs. In order to sustain HF,data should be incorporated with outcome monitoring systems to track client improvement and the success of the HF program over time. The data that were collected can also be used at the client level to set

goals and regularly monitor progress via service plans and assessments. One word of caution for the evaluation is not to use shelters as a barometer of success, as that would set them up to be removed. There will always be a need for shelters for newly homeless populations or other populations that do not fit, or are not yet integrated into the HF model.

### 7.1 Implementation Model

In order to be successful, HF programsmust be implemented effectively. Implementation refers to the process of establishing and delivering a program in a particular setting (Durlak&DuPre, 2008). Durlak and Dupre (2008) suggest that program implementation occurs in four stages: 1) disseminating an idea about a new, innovative practice and the value of this practice to a community; 2) adopting the new program in a given community or by a particular agency; 3) implementing the program during a trial period; and 4) sustaining the program over time. Within each of these stages, there are many considerations and variations that can occur when implementing HF, depending on the specific needs and realities of a given location.

An implementation model for HF was developed based on the process evaluations conducted in Vancouver, Edmonton and Regina and supplemented by a review of the literature, including case studies of Housing First initiatives implemented in Canada and around the world. There are four phases to the proposed implementation model similar to Durlak and Dupre's (2008) four stages of implementation (See Figure 3). The goal of phase 1 is to obtain support and funding. Once enough support has been received to obtain funding, the second phase of obtaining resources begins. Once everything is in place to start the HF program, the third phase begins with accepting clients and starting the program. The goal of the fourth and last phase is to sustain the program. This phasealso begins once the program starts. Several components of each phase may overlap with another. The model in Figure 3 follows a 5-year plan which may be achievable for Saskatoon since Nanaimo, a small city in British Columbia, also implemented a 5-year action plan (City Spaces, 2008b).

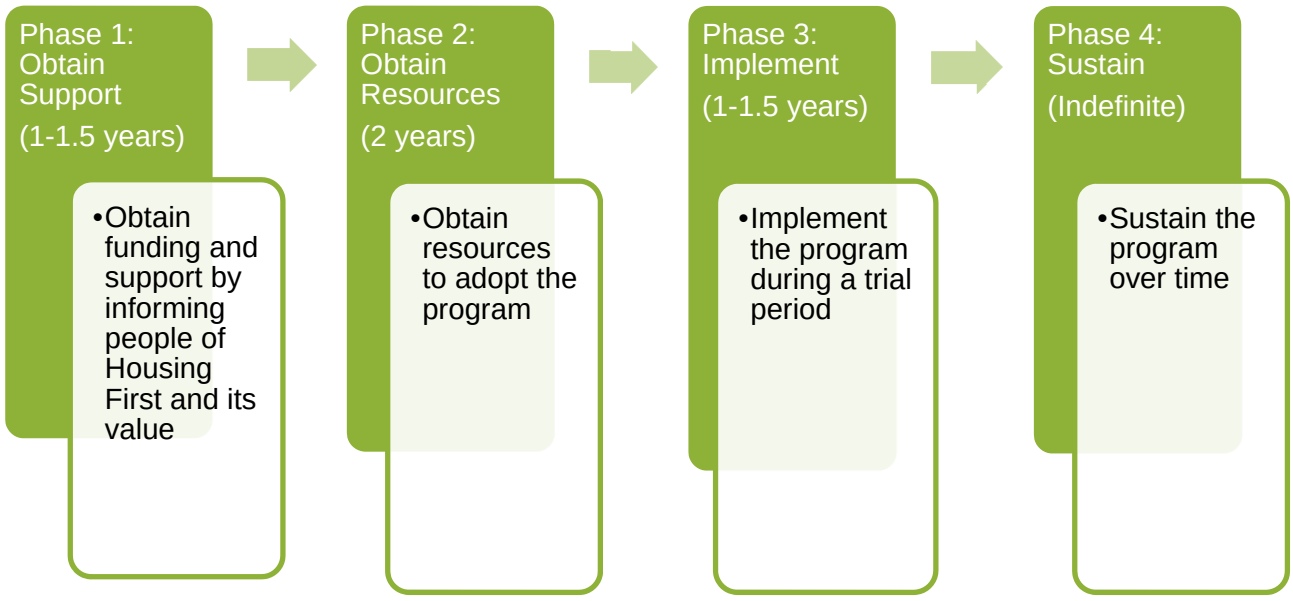



*Figure 3*.Phases of the Housing First implementation model.

### 7.1.1 Phase 1: Obtain Support

The goal of Phase 1 of the implementation model is to obtain funding and support by educating the community and governments about HF and its value (See Figure 4). In order to accomplish this goal reducing homelessness has to be an important issue for the public and governments and they need to be open to ideas to obtain support and funding. Phase 1 assumes that there are homeless ICMDs in the community and funds to finance the plan. Ideally, it will take 1 to 1.5 years to obtain support and funding for HF. The results of the process evaluation informed the development of the first phase of the Housing First implementation model in several ways. The main methods used to obtain support are media strategies, community involvement and utilizing experts.

**Establish goals.** An important early task is to establish key goals and a strong philosophy that is agreed upon by various stakeholders (e.g., partners, landlords, housing/property managers, service providers) and which fits the local context while remaining faithful to the guiding principles of HF (Corporation for Supportive Housing [CSH], 2013; Gaetz, 2013b; Scott, 2013b). Establishing clear goals and strategies was also on the action plan for implementing HF in Nanaimo and can aid in decision-making (City Spaces, 2008b).

**Media strategies.** There are several strategies that can be used in order to obtain support. Successful strategies to overcome resistance and establish an atmosphere of change have centred around media strategies that disseminated information about the value of HF, the possibilities it is able to achieve, and evidence that it works to service

providers, politicians, policymakers, and general public (Gaetz, 2013b) as a means of garnering their support. Media strategies should be targeted to the general public, governments, landlords, service providers, housing providers, politicians, and policy makers. The media strategies can include personal stories in documentaries and websites. Showing documentaries highlighting the possibilities that have been realized in other communities has been another option employed by some communities (Gaetz, 2013b; Gaetz& Scott, 2013).

**Community engagement strategies.** Messages should ensure that HF is viewed as an opportunity, rather than a threat, even if it may result in changing the mission and roles of existing services (Gaetz, 2013b). For instance, the City of Lethbridge successfully achieved community buy-in for HF by using community engagement strategies that focused on the key messages that housing is a fundamental right, explaining what it will take to end homelessness in Lethbridge, and dismantling myths and beliefs about homelessness and housing that are counterproductive to HF (e.g., individuals who are homeless should prove themselves before being provided with housing; Scott &Gaetz, 2013).

Community engagement strategies involving frequent communication and engagement, public workshops, and ongoing consultation with government and community partners, including landlords, have also been successfully used to alleviate concerns about HF and build support (Gaetz& Scott, 2013; Scott &Gaetz, 2013).These meeting should be run by private trained communications experts and experts from communities with HF. These experts should also inform the community of new developments.

**Overcoming resistance.** A variety of effective strategies for obtaining support for HF initiatives is required, particularly in smaller cities where the HF philosophy is new. For example, the importance of gaining support was most evident in Regina, where several barriers and challenges to housing ICMDs were encountered. McEwen Manor faced resistance from local neighbourhood residents and businesses who did not want their “clientele” living next door to them. McEwen Manor overcame this resistance by unofficially taking a “good neighbour policy” and being as helpful and accommodating as possible in response to the requests and opposition they were facing. Staff at MM and PCA in Vancouver also had difficulties accepting that supportive housing residences may be permanent for some ICMDs, highlighting the fact that this might be a difficult view to change and should be targeted in media strategies. Needs analyses and homeless counts may be important to help gain support in Regina. For example, informing the community about the long waitlists and low client turnover at supportive residences may illustrate the urgency and need for HF.

Facilitating community acceptance of HF was also a goal in the implementation plan for the city of Nanaimo. To achieve community acceptance, the plan was to involve the

community early on, disperse housing and services, communicate with all those involved on an ongoing basis and establish good neighbour agreements (City Spaces, 2008b). Support from formal and informal community stakeholders is crucial to successfully implementing HF because it often reflects a substantial change in communities' and organizations' housing philosophies (Nelson et al., 2014).

Common barriers to HF initiatives are local resistance from both professionals and communities (Gaetz, 2013b). Professionals are concerned about changes to the status quo, with fears that HF may undermine existing community efforts, result in job losses, or be ineffective in reducing homelessness being commonly cited (Gaetz& Scott, 2013; Gaetz, 2013b). The general public is concerned with what is commonly termed "not in my backyard" (NIMBY; Greenwood, Stafancic, Tsemberis, & Busch-Geertsma, 2013; Scott &Gaetz, 2013; Scott, 2013c). As a result, time and consideration has to be given to ensuring the readiness for change among community members and service providers to ensure that HF is not pre-emptively dismissed.

**Experts.** Another successful strategy is bringing in experts from other communities that have successfully adopted HF (Keller et al., 2013). They can use their firsthand experience to provide local inspiration, convince skeptics, and address concerns about barriers to implementation (Gaetz, 2013b). Experts can share their own missteps and lessons learned to help communities avoid repeating some of the same mistakes (Gaetz& Scott, 2013). Researchers and a trained task force of experts are needed to prepare briefing notes, write a literature review, conduct a needs analysis and homeless counts, and put together a proposal / HF plan.

Above all, however, strong leadership is needed to guide the process of creating an atmosphere of change and building the support that is needed from diverse groups to make HF a viable option (Gaetz, 2013b). Regardless of how the readiness for change is established, the community must be brought along and in support of HF for implementation to occur.

**Strong leadership/stewards.**Throughout the first phase, it is important to have strong leadership. The importance of strong influential leadership was made evident in Edmonton. Edmonton's 10-year plan (*A place to call home*) started out as a Mayor's Task Force. The Task Force was comprised of individuals who had little experience with homelessness but had a lot of influence in the city. The Task Force signed off on the plan and established the Homeless Commission, a committee of the Edmonton City Council, to champion Edmonton's plan.

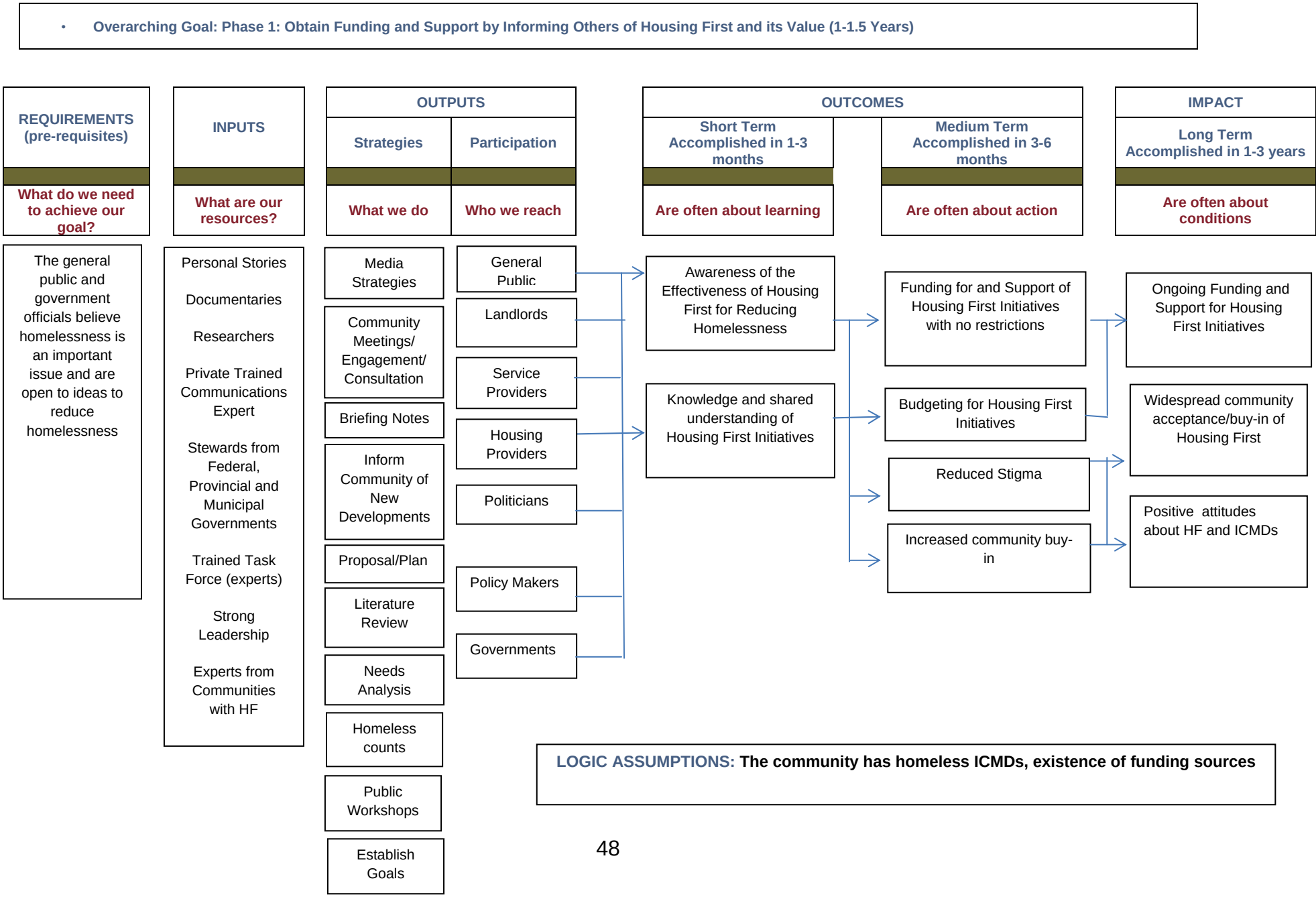
Strong leadership that effectively inspires, drives, and manages change is needed to shepherd the process of establishing HF, garnering support for a shared vision (Gaetz, 2013b) and is one of the strongest influences on the successful implementation (Durlak&DuPre, 2008; Torrey, Bond, McHugo& Swain, 2012). Leaders who have strong-

decision making skills, provide clear direction, foster an environment of shared learning and respect amongst staff, understand the HF model, and have extensive experience working with various populations were identified as being strong facilitators during the implementation of the At Home/Chez Soi project (Nelson et al., 2013, 2014). Stewards from federal, provincial and municipal governments are needed to propose the plan to governments, the general public, service providers, housing providers, politicians, and policy makers.

**Funding.**Housing First initiatives seem to be most successful when there is an initial short-term investment into the program that will allow it to cover up-front costs such as rent supplements (e.g., questions such as for how many people and for how long need to be considered), program staff (e.g., the staffing of housing and support services teams), and the costs incurred as a result of needing to repair damaged units (Gaetz, 2013b). Further, funding for HF programs must be multi-year. Edmonton's HF Initiative received funding from federal, provincial and municipal governments and also received annual operating funding from the province. Without a certain level of commitment to the program and a guarantee for long-term support for the individuals housed through HF, the initiative will be setting itself up for failure and the clients will be at risk for housing instability (Gaetz, 2013b). Funding from federal, provincial and municipal governments helped build PCA, CP and MM; nevertheless funding limited the programs offered at MM. McEwen Manor does not receive multi-year funding but pays the mortgage by rents obtained from clients and the commercial office space. To be successful, HF must be seen as a serious investment by the community and its potential clients.

Nanaimo's *Housing First and Harm Reduction Action Plan* (City Spaces, 2008b) outlined the new costs associated with the plan and who would be funding those costs. For example operational costs of the new housing units and rent supplements were expected to be funded through BC housing.

*Figure 4*. Phase 1: Gain Support



### 7.1.2 Phase 2: Obtain Resources

The goal of the second phase of the implementation model is to obtain or restructure resources to adopt HF (See Figure 5). Phase 2 begins once funding has been obtained. The most successfully funded HF initiatives have been when there is funding from various levels of government and non-profit agencies (e.g., Edmonton) and when there is an initial short-term investment followed by a self-sustaining funding mechanism (e.g., MM). Ideally this phase would take approximately two years to implement and assumes that affordable housing is available. The research conducted in Vancouver, Edmonton and Regina provided a number of suggestions of how to obtain resources for HF initiatives. One effective method used in Edmonton to obtain resources was through Homeward Trust (HT), a non-profit organization, acting as the funder and the management body responsible for the implementation of the plan. As the management body, Homeward Trust coordinates or funds most of the Homeless Commission's activities. Homeward Trust also plays a reporting role and sends the Commission data yearly for their report to the Mayor and Council.

**Stewards.**We need to continue to have stewards for HF. Communities must determine who will be the steward of the HF initiative and who will be tasked with leading its implementation. Two common stewards of HF initiatives in Canada have been municipalities (e.g., the City of Lethbridge) or non-profit organization established specifically to be the steward of HF (e.g., Calgary Homeless Foundation, Edmonton's Homeward Trust; Gaetz& Scott, 2013, Scott, 2013a; Scott &Gaetz, 2013).

**Organizational and governance structures.**The structures established in Edmonton appear to be effective at implementing HF. A Board of Directors including an ICMD advisory committee should be established. Housing First initiatives must develop organizational and governance structures to establish defined roles and responsibilities within the scope of the initiative (e.g., Homeward Trust). These structures increase the opportunity for collaboration and partnership building, and outline agreed upon processes for communication, and conflict resolution (Durlak&DuPre, 2008; Nelson et al.,2014). Structures that allow for shared decision-making and community involvement have been found to lead to better implementation by creating mutual trust and openness, sharing of responsibilities, increased consensus and enhanced program sustainability (Durlak&DuPre, 2008). Organizational structures that build upon existing networks and committees, such as Nanaimo's Action Plan, can also ease the implementation of HF (City Spaces, 2008b).

**Using services already in place.** The easiest way to implement HF is to work with existing structures. Therefore, whenever possible, it is recommended that HF initiatives be embedded in broader planning frameworks, such as a 10 year plan to end homelessness (Scott, 2013a; Gaetz& Scott, 2013; Canadian Alliance to End Homelessness, n.d.). Cities

with the most success in reducing their homelessness population are those that have an integrated systems approach where all services and program elements within the homelessness sector, including relevant mainstream services and supports, are guided by the philosophy behind HF and are expected to support and operationalize HF by playing a specific role in the larger system (Gaetz, 2013).

Staff and stakeholders in Edmonton believed the ability to build on structures that were already in place in the city, including making use of the services and structures offered by wellness centers and other services eased the implementation of HF in Edmonton. The ability to make use of the systems and services already in place is one of the hallmarks of Edmonton's decentralized system. Clients are encouraged to use the services available to all Albertans, with a focus on using them in a responsible way to decrease emergency service usage. A large city like Vancouver also has many structures in place (e.g., barrier-free housing options, ACT teams, outreach, etc.) that would ease the implementation of HF.

When integrating HF into an overarching planning framework, it is important to clearly layout how existing support services (e.g., shelters, counselling services, outreach services) can be reorganized to accommodate HF programming. New programs are not always needed upon the introduction of HF into a community; oftentimes a reconceptualization of how services are delivered and a resulting change in practice is sufficient (Gaetz, 2013b). When realigning service delivery, it is vital to ensure that each service provider or sector is aware of the role that they and others are expected to play and how they can accomplish these mutually agreed upon HF goals with minimal service duplication and service gaps (Gaetz, 2013b). It is also necessary to remember that, in a systems approach to HF where all organizations are expected to support the philosophy of HF, not all providers will necessarily be doing the work of the HF initiative. Some partner organizations will be expected to deliver services to clients based on their functions in such a way that facilitates HF without directly delivering HF programming (Gaetz, 2013b). Thus, to further develop role clarity, it is recommended that a system of care model be introduced which specifies how service agencies are expected to collaborate and coordinate intake and exit strategies and how links will be strengthened between homelessness services and mainstream services (Gaetz& Scott, 2013).

The At Home/Chez project offers an illustrative example of the importance of role clarity. Their implementation evaluation revealed that, at some sites, partner agencies were not clear about "who does what and who works for whom" (Nelson et al., 2014, p. 25). The lack of role clarity contributed to delays in obtaining housing for consumers and a lack of cohesion and contact among clinical and housing teams and threatened the effective delivery of service to clients. Rog and Randolph (2002) suggest that it is particularly important to establish role clarity when more than one site, agency, or HF team is involved in delivering the initiative.

**Data management system.**Implementing a data management system is crucial for HF initiatives. A data management system including an intake assessment tool is needed in order to maintain a consistent method of collecting and sharing information about the HF clients and also for evaluating the program. Ideally, any new HF initiatives should include a data management and evaluation component to collect data on outputs and outcomes. By systematically collecting outcome data, it will be possible for new initiatives to demonstrate evidence of their success; such evidence can be used to help build momentum as the initiative develops, and support its future sustainability (Greenwood et al., 2013; Scott &Gaetz, 2013).

One potential challenge that was apparent in Regina and Vancouver was the lack of a data management system. For example, records were not being kept electronically and were not collected in a systematic and complete manner. One challenge faced by CP in Edmonton was the variability and inconsistency in the data collected using the SPDAT. Therefore, ongoing staff training is required when implementing such tools. Gaetz (2013b) also recommends that point-in-time homelessness counts be conducted in any city embarking on a HF initiative to establish a baseline of the homeless population. Future counts after the HF initiative has been implemented can then help the city monitor the progress that has been made in reducing its homeless population. Edmonton has successfully used such counts to show that, in 2012, they were able to decrease the city's homeless population by 30% in three years after introducing HF (Homeward Trust, 2012b).

**Housing Options.**Congregate and scattered site housingunits need to be identified and/or built in order to provide appropriate supports and options for ICMDs. In particular, congregate-type settings may be viable alternative for those clients who are not successful in scattered-site housing (Nelson et al., 2013). In cities that have included "mixed" models, program deliverers have consistently found that some clients prefer scattered site housing while others prefer institutional or congregate models (Gaetz, 2013b; Gaetz& Scott, 2013). A study conducted in Copenhagen found that most ICMDs were housed in congregate units however some transferred to independent housing due to the negative effects of substance abuse (Benjaminsen, 2013). The study suggested congregate housing be reserved for those who cannot live independently even with ACT teams support.

More housing options were available in Edmonton and Vancouver than in Regina. Edmonton and Vancouver had congregate and scattered site options. However, Regina's options for congregate housing for ICMDs was limited and had barriers for entry. Overall, residents of the three congregate residences examined in the process evaluations were satisfied with their housing. Residents reported congregate housing was appealing because of the security, comfort, cleanliness, sense of belonging, and supports. Some of the negative aspects reported were drug use and rules, particularly regarding visitations.

**Congregate housing.** Several recommendations should be considered when building a congregate supportive residence for ICMDs. McEwen Manor in Regina found that having a strong business plan and a partnership between an agency with expertise in housing development and one with expertise in the needs of ICMDs was helpful in the success of the residence. Clients interviewed at PCA appreciated the optional in-house support services such as medication distribution/management, meals, support groups and social activities. Staff at PCA felt that these in-house services were a strength of the program. Support service workers (e.g., doctors, psychiatrists) also made house calls to PCA, which residents and staff felt helpful since it was difficult for some ICMD residents to keep appointments. The variety of services provided at PCA is in part due to the fact that it is run by Coast Mental Health which also provides a wide variety of programs and services and has pre-existing community connections.

A number of recommendations for implementing congregate housing have also been reported in the literature. For example, Pearson et al. (2007) found that congregate supportive residences for ICMDs that provide services by the primary service provider who owns or controls the residence is effective because it enables the service providers to provide a high level of supervision to clients and to respond quickly to the challenges that arise. It also provides a cost effective alternative to highly credentialed ACT teams.In this model, it is common for residences to provide as many support services as possible in-house and for them to connect clients to services located in the community for any supports they cannot feasibly provide themselves. However there are some limitations of this model. For example, in-house support services may limit client choice for housing and reduce normalcy of the living environment (Boydell& Everett, 1992; Kirsh et al. 2009; Yanos, Barrow, &Tsemberis, 2004). In addition, too many visits with case workers may hinder recovery(Nelson et al., 2012, 2014).

Consequently, program administrators should make informed decisions around the rules that they do establish around support service delivery. Further, program administrators should be prepared to be tolerant within a pre-defined set of parameters when clients do not abide by any rules put in place and problematic behaviours that may occur with ICMDs in order to foster a long-term relationship and tenancy (Gaetz, 2013b). In fact, residents at PCA, CP and MM all complained about rules and in particular guest/visitation policies. A HF project implemented in Lisbon in 2009that focused on client choice did not have any guest rules allowing ICMDs to share their home with friends or family of their choice (Ornelas, 2013). The program was deemed successful as only 16.2% of clients returned to the streets. Guest policies and rules do not appear to fit a HF model and choice appears to be effective in maintaining housing for ICMDs.

The availability of supports is another issue that should be considered by program administrators when setting up support services for HF initiatives. It is recommended that supportive housing be staffed 24 hours per day, particularly when serving individuals with

severe mental illness, to ensure that residents always have ready access to support when crises or problems emerge (Pearson, Locke, Montgomery &Buron, 2007). For example, one challenge reported at CP in Edmonton was the fact that they could not afford to have 24 hour support available on-site.

Another issue specific to supportive housing residences is that residences must decide on the types of services that they will make available to clients internally versus those they will encourage clients to connect with through external supports, including mainstream services (CSH, 2013; Gaetz, 2013b). Further, it should be considered how supports can be offered in conjunction with each other. Past research (Drake &Mueser, 2000; Morse et al., 2006) has suggested that, with respect to ICMDs, it is most effective to offer treatment that integrates both mental health and substance abuse treatments including services such as assessment, assertive case management, motivational interventions (for those who do not recognize their substance abuse problems), behavioural interventions (to help clients attain or maintain abstinence), family interventions, housing, rehabilitation/recovery, and psychopharmacology. In fact, integrated recovery programs combined with supportive housing have been found to facilitate higher and more expedient rates of recovery (Morse et al., 2006).

Congregate buildings were found to be effective for housing ICMDs. Once in congregate housing, most ICMDs stayed. For example, at PCA some residents were there for over 2 years since it opened and the ICMDs who took part in the research were living at PCA for over 1 year on average. However, interviews with staff in Vancouver and Regina indicated that it may be difficult for staff to accept supportive residences as being a permanent home to ICMDs. Permanent supportive housing is more in line with the HF philosophy and has been found to be preferred by residents (Kirsh et al., 2009). Specifically, permanent housing has been associated with providing residents with a sense of stability and decreased stress that allows them to manage their mental health issues and facilitates their recovery process. The results indicate that when implementing HF, housing providers should be made aware that in order to remain in stable housing some residences will require supports on an ongoing basis, as without these supports they will be at risk again of losing their housing (Kirsh et al., 2009).

Residents at PCA, CP and MM all complained about the rules and guest policies. One method of reducing these complaints may be to separate service providers from housing staff. Guiding HF philosophy recommends the separation of landlord/financial support from the emotional or programmatic support to clients so that workers are better able to develop trust with clients (CSH, 2013; Gaetz, 2013b; Greenwood et al., 2013). However, property/housing management staff and supportive services should understand each other's functions and communicate frequently. To facilitate this division, CSH (2013b) recommends creating an eviction policy that specifies how all supportive housing partners will work together to promote housing stability, procedures for notifying each other when

there are unmet service needs or safety/maintenance concerns, and the forums where housing and support services staff can discuss roles, current issues, gaps in services or operations, and coordinate efforts.

As a note of caution, the separation of housing and support service functions resulted in a lack of contact and cohesion between teams (i.e., ACT, ICM, and housing teams) at three sites in the At Home/Chez Soi project hindering HF implementation which seemed to be exacerbated by housing and support teams being located at two different locations within the city (Nelson et al., 2013). In particular, the limited contact housing team members had with clients hindered conflict resolution.

Whenever possible, clients should be placed in neighbourhoods where they will have easy access to public transportation, their social connections, and community resources and amenities, including grocery stores, shopping, recreation opportunities, and support services as it will help them with their recovery and wellbeing (CMHC, 2002; CSH, 2013; Kirsh et al., 2009). In fact, a lack of public transportation was an identified implementation barrier at one of the At Home/Chez Soi sites (i.e., Moncton) as it made it difficult for clients to attend appointments for health and social care, visit the food bank, or maintain relationships with friends and family. Community integration has also been associated with increased housing stability (CMHC, 2002). The residences evaluated in Vancouver, Regina and Edmonton were centrally located, allowing access to a wide variety of services, programs and more. Even though PCA in Vancouver was only one or two blocks away from Vancouver's notorious drug-infested East Side, residents were happy with the location and felt safe and secure.

Any supportive housing residences that are built specifically to house ICMDs should be designed so as to minimize any possible stigma clients might experience by living there. That is, buildings should physically blend into the surrounding neighbourhood (CMHC, 2002; Kirsh et al., 2009), be physically attractive and should meet or exceed community standards with respect to their scale, design, appearance, and maintenance (e.g., PCA). In addition, stigma may also occur within the residence. For example, one client felt he/she was being identified and judged as being an ICMD at MM. Therefore, if possible, a residence specifically for ICMDs is recommended.

Other design considerations that must be taken into account include the security for the building (e.g., buzzers to apartments, security camera, and access to/the positioning of apartments), accessibility features to accommodate individuals with physical disabilities, independent living features (e.g., separate bedrooms, private bathroom and kitchen, adequate living space for essential daily activities, such as cooking, eating, sleeping, and studying), the number of bedrooms for expected household composition, and access to common rooms (either onsite or offsite for programming; CSH, 2013; Gaetz, 2013b).These features were common at the residences reviewed and most likely contributed to residents'

positive perceptions of the cleanliness and safety of the buildings.The design of the building should also take into consideration the needs of ICMDs, such as providing built-in furniture and providing furniture as these were considered strengths at MM in Regina. Having the option of furnished or unfurnished suites would be ideal in a HF model.

The development of a congregate supportive housing unit for ICMDs is likely to face resistance as it did for MM. Resistance from businesses and citizens living in the neighbourhood is one of the biggest barriers that may be encountered by developers looking build a new supportive housing residence (Scott, 2013c). Often, these groups have concerns about safety and security, which can be mitigated by openly discussing measuresput in place to address community issues and problems and engage the community (Gaetz& Scott, 2013). Housing project developers may do so by attending neighbourhood association meetings, participating in community improvement activities, listening to and addressing neighbours and community members' concerns about the housing, seeking input from neighbours about the housing project (i.e., its design, development, and operating plans), incorporating (when possible) design elements that will help meet existing community needs (e.g., meeting space), and providing regular updates throughout the development process to neighbours (CSH, 2013). Being responsive to problems and concerns raised by neighbours is key to maintaining good relationships with the community (Gaetz& Scott, 2013). It will also ultimately help the supportive housing build relationships with the community to assist residents with becoming integrated into the community and providing them with opportunities to demonstrate that they are "good" neighbours (Gaetz& Scott, 2013). For example, MM overcame resistance from the community by unofficially taking a "good neighbour policy" and being as helpful and accommodating as possible in response to the requests and opposition they were facing. The HF project in Lisbon also successfully brought together neighbours, landlords and team members to mediate and discuss any conflicts (Ornelas, 2013).

An illustrative example of how to build community support is reflected by the building of The Vivian in Vancouver (Gaetz, 2013c). Here, the HF project built positive relationships and addressed NIMBY concerns by: 1) educating local community members about the myths and truths of vulnerable populations and the broader social benefits; 2) holding community meetings to discuss neighbours' and stakeholders' concerns to develop solutions; and 3) adopting a "good neighbour policy" that required all residents living at the Vivian to sign a Neighbour Agreement outlining the expectation of what was expected of the women to maintain good relationships with the community (Scott, 2013c).

**Support services.** Supports should match the acuity of ICMDs and ACT and ICM teams need to be hired and trained. One common system-level or city-wide approach to HF is to establish two types of support teams that provide varying levels of specialized supports to clients who are dispersed across the city. These teams are typically known as

assertive community treatment (ACT) teams and intensive case management (ICM) teams. Edmonton and Vancouver currently use these teams. Staff and stakeholder interviews in Vancouver emphasized the importance of support teams and how effective they were in helping to house ICMDs. ACT teams provide higher intensity supports to clients and are typically characterized as a multidisciplinary team of professionals (e.g., psychiatrists, doctors, social workers, nurses, substance abuse specialists, peer support workers, case managers, and/or employment and education specialists) that provide wrap-around services to clients (Gaetz, 2013a). In fact, stakeholder interviews in Edmonton emphasized the need for more wrap around services. The specific professionals that comprise an ACT team may vary by community and may be dependent upon the availability of specialists and the client needs that exists (Gaetz, 2013a; Nelson et al., 2013). These teams are mobile, meet regularly with clients and with each other, and provide supports to clients 24 hours a day. ACT teams help address the needs of ICMDs, including helping them access psychiatric treatment and rehabilitation services. The services offered are ongoing until the client's level of need changes and are informed by client choice, peer support, and a recovery orientation (Gaetz, 2013a).

In contrast, ICM teams tend to help clients who generally have fewer needs, but who may require intensive support for a shorter, time-limited period (Gaetz, 2013b). ICM teams may be comprised of a case manager and members of the HF housing and support services team, or the responsibilities may fall primarily to a lone caseworker. ICM teams typically focus on using case management to broker services that will help clients maintain housing and achieve an optimum quality of life. This approach is also informed by a recovery-centred orientation. Areas in which services may be provided to clients include enhancing life skills, addressing physical and mental health needs, helping clients engage in meaningful activities, and encouraging clients to build social and community relationships (Gaetz, 2013a). Case managers are typically available 12 hours a day, seven days a week; ICM teams tend to carry higher caseloads than ACT teams (Gaetz, 2013a).

There is evidence that supports the effectiveness of both ACT and ICM teams (Gaetz, 2013a). However, ICM and ACT team support cannot be provided by untrained service providers or paraprofessionals. Therefore, this model is only possible if there is sufficient numbers of professionals available to join these teams (Gaetz, 2013b). In addition, the availability of an adequate service array will, in part, dictate the extent to which ICM teams are able to function effectively (Nelson et al., 2013, 2014). ICM teams tend to rely on accessing and connecting clients to community-based services. Thus, it is important to examine the global community context in which an ICM team will be operating in and to determine whether such a model will be feasible giving the existing range and availability of community-based services as such factors are beyond the control of the ICM team (Nelson et al., 2013, 2014).

**Staff.** Staff with the right training and personalities was found to be important components of successful housing programs. For example, interviews with clients, staff and stakeholders in Edmonton revealed that staff that are educated, trained, friendly, tolerant and compassionate are ideal. Everyone hired must be trained professionals with leadership qualities, tolerance and dedication. At the local organizational level, strong leaders shape the work environment and influence the degree of adherence the organization will have to HF principles (Nelson et al., 2014). In particular, leaders and organizations should strive to establish positive team environments which are supportive, open, flexible, cooperative, and characterized by trust, mutual understanding, and a shared commitment to HF values (Nelson et al., 2014). In fact, some research has found that staff morale has been associated with increased program effectiveness (Kirsh et al., 2009). Further, attention should be paid to developing team cohesion (particularly when housing and support services are separated) using strategies such as structured meetings, formal training, (all)-team events, and locating housing and support service teams in the same office space. In Vancouver, staff interviews indicated that the joint training between PCA and other CMH housing agencies is beneficial. In addition, team diversity should be valued and used to facilitate cross-team learning, breaking down hierarchal relationships across professionals and within teams, and provide participants with a wide array of expertise (Nelson et al., 2014).

Strong frontline staff teams that have the right combination of technical and interpersonal skills also have a substantial impact on how programming is actually delivered to clients (CSH, 2013; Greenwood et al., 2013; Kirsh et al., 2009; Nelson et al., 2014). Some of the knowledge, attributes, and skills that have been identified as being important for staff to possess include:

- Knowledge of mental health and addictions issues
- Knowledge of evidence-based best practices, such as trauma-informed care and integrated dual diagnosis therapy
- Knowledge of community resources and social services
- Assessment skills
- Commitment to HF and a client-centred philosophy
- Attitudes/personalities characterized by openness, respect, adaptability, empathy, non-judgemental, self-awareness, optimism, and ability to hold hope for clients
- Knowledge and experience of techniques that facilitate client behavioural change including motivational interviewing, stages of change model, non-coercive assertive engagement, and personal centred planning
- Strong communication skills, active listening skills, and problem-solving techniques
- Knowledge of relevant cultural issues

- Ability to build and maintain relationships characterized by dignity, respect, trust, and choice
- Ability to tailor services to clients by taking into account their age, gender, culture, background and/or disability

To help staff continue to build or maintain their knowledge and skills, it is important for HF initiatives to incorporate training for staff (Keller et al. 2013). Training may occur formally and informally but, as a training strategy, Nelson et al. (2013) recommend that formal training be developed and implemented rather than to rely on on-the-job training. Further, Durlak and DuPre (2008) recommend that training for staff focus not only on technical knowledge but also on increasing their motivation, self-efficacy, and expectations for their own performance. They posit that service providers who recognize the need for a given intervention, believe that it will work, feel confident in their ability to implement it, and have the necessary skills are more likely to implement programs with a higher degree of fidelity and at a greater dosage (Durlak&DuPre, 2008). Retraining may also need to be periodically offered to staff to ensure continued program fidelity (Durlak&DuPre, 2008). However, Torrey et al. (2012) warn that training alone will not be sufficient to guarantee the effective delivery of HF, especially if organizations are required to do different types of work or work in different ways as a result of joining the HF initiative. In this case, training should also be accompanied by changes to the work flow to ensure corresponding changes to workplace practices occur. Competitive wages and/or education and training was recommended as one method of reducing staff turnover and attracting appropriate applicants in the interviews conducted in Regina.

**Landlords.**Opportunities and benefits should be provided to landlords. Landlords willing to participate should be identified and methods of providing benefits for landlords should be established including rental supplements. Rental supplements have been found to be a successful strategy in several sites in that they allow landlords to continue receiving market rent, while keeping rent affordable for clients (Gaetz, 2013; Nelson et al., 2013). In fact, Nelson et al. (2013) attribute housing subsidies to client success in the At Home/Chez Soi project. Rental supplements may be administered in a variety of ways, including by not-for-profit housing providers, housing authorities, and government agencies that provide social assistance payments (Keller et al., 2013).

Effective relationships with landlords are critical to the success of HF initiatives. Participating landlords should be fully informed of the procedure for HF, roles, including whom to contact and what to expect. In addition, agreements should be maintained by HF with the landlord to build relationships. Housing First should be attractive and appealing for landlords as some may be nervous to rent to clients who have previously been homeless or who have known histories mental health, substance use, or behavioural problems (Gaetz, 2013b; Scott, 2013d). Some strategies that have been employed in the past

include promising that the HF team will: a) provide landlords with a guarantee that rent will be paid each month; b) hold the lease and then sublet the units to clients; c) cover any costs associated with cleaning and repairs stemming from damages; d) perform any evictions that are necessary; and e) take responsibility for screening and intake; and f) provide prompt responses when issues arise (Gaetz, 2013b; Greenwood et al., 2013; Nelson et al., 2013; Pearson, Locke, Montgomery, &Buron, 2007). These types of arrangements with landlords have been well received as they offer landlords with funding and supports they may not otherwise receive when managing their rental properties and being part of HF offers a guarantee of tenancy (Gaetz, 2013b).

In some cities, there has been confusion among landlords about what organizations actually belong to the HF initiative and which organizations operate independent of it. There have been some instances in which landlords erroneously believed that clients were in the HF program and blamed the HF team when the supports and guarantees promised by the HF team did not materialize when issues emerged with the clients, as the referring organization did not have the process, protocols, or supports of a HF team in place (Scott &Gaetz, 2013). When these types of issues occur, landlord support for HF programs are threatened. Such issues also speak to the need to ensure that the HF team and its partner organizations are made known to landlords.

The At Home/Chez Soi project also revealed some challenges in building and maintaining relationships with landlords (Nelson et al., 2014). Stigma and racism from landlords presented themselves as significant challenges at some sites, particularly for clients with mental illness. The amount of energy that was needed to sustain and repair relationships with landlords after evicting tenants was also unexpected and served to threaten the HF team's access to those landlords' housing units. Further, some sites were not able to keep all of the "guarantees" they initially promised landlords (e.g., frequent, regular visits and prompt repairs to damaged units) resulting in some landlords leaving the program. Some landlords also indicated that they were displeased with the amount of contact they had with the housing and clinical teams and felt that the teams were unresponsive to both their needs and the needs of the tenants (Nelson et al., 2013). Landlords also perceived that it took longer for HF tenants to acclimatize to the norms of their buildings than non-HF tenants which imposed on the landlord's time. Finally, landlords indicated that they were sometimes confused about whether they should contact the housing or support team when an issue emerged with clients and reflects another potential challenge that may be associated when there is a division between housing and social supports. Lisbon's HF programonly used one unit per apartment to promote integration (Ornelas, 2013); however this may also help attract more landlords because fewer ICMDs in the apartment would mean less work for landlords.

**Rental costs.** Some HF programs limit residents' rent costs to no more than 30% of their income (e.g., MM), while CSH (2013) recommends that rents charged by supportive

housing residences should not be more than 30% of the client's income and never more than 50%. However, as more individuals are housed, the demand for rental supplements may exceed the amount of available funding unless some clients can eventually be weaned off or placed in affordable housing options (Gaetz, 2013b). Thus, in some cities, if the affordable housing market is lacking, housing stock needs to increase to meet the inevitable limits of rental supplement programs. Gaetz (2013b) suggests that HF should be linked to an affordable housing strategy focused on increasing housing supply. Strategies that may help build affordable stock include direct investments into new housing, changes to zoning (i.e., inclusionary zoning, legalizing and regulating secondary suites), and financial incentives for the private sector.

**Local context.**The local context of a given city or community should also be considered when implementing HF. Factors such as city size, available housing stock, vacancy rates, local tenancy legislation, local economic and demographic characteristics will influence how HF is implemented in a given city (Gaetz, 2013b; Keller et al., 2013). Similarly, political and housing context, size and capacity of existing service and housing provider organizations, existing array of services and supports, and cultural beliefs, values, and practices will shape how HF is adapted to local contexts (Keller et al., 2013). For example, some communities may focus on permanent supportive housing and others on subsidized housing and rapid rehousing (Gaetz, 2013b). Other communities focused their efforts on certain groups, such as Aboriginal persons, youth, families, and the chronically homeless, due to their disproportionate representation among the homeless population and greater risk of becoming homeless (Scott; 2013a; Scott &Gaetz, 2013). The characteristics of a community's population may also influence the way governance and organizational structures are designed and the types of strategies employed to increase support for HF.

The programs under review in Edmonton, Vancouver and Regina all took the local context into consideration in varying ways. For example, PCA included youth and HIV programs. Edmonton's HF initiative prioritized Aboriginal individuals who were homeless by making it a requirement that 50% of clients who were housed through HF be Aboriginal. Moreover, the HF initiative recognized that it was necessary for Aboriginal community leaders to be an explicit part of their governance structure (Scott, 2013a).

In addition, the City of Lethbridge focused efforts on addressing homelessness among on First Nations individuals who previously lived on reserves by developing partnerships with cultural organizations and neighbouring First Nation communities, educating First Nations living on reserves about what to expect when renting in Lethbridge, creating short-term transitional homes to help with the transition from the reserve to an urban setting, and mitigating issues stemming from racism among landlords (Scott &Gaetz, 2013). Lethbridge also identified that a large population of its workforce were educators and focused on raising awareness of, and building support for, HF (Scott &Gaetz, 2013). In

the At Home/Chez Soi project, some of the sites adopted anti-racist/anti-oppression frameworks in light of the racialized groups that comprised their populations.

When determining how to best make a new HF initiative fit into a community, it is helpful to complete a community assessment that engages the whole community to determine the community's specific needs with solid data (Scott &Gaetz, 2013; Gaetz, 2013b). In doing so, all sectors, partners, and individuals involved in, or affected by, the HF initiative will theoretically have the opportunity to inform the implementation of the strategy and identify what they deem to be the most important components of the initiative.

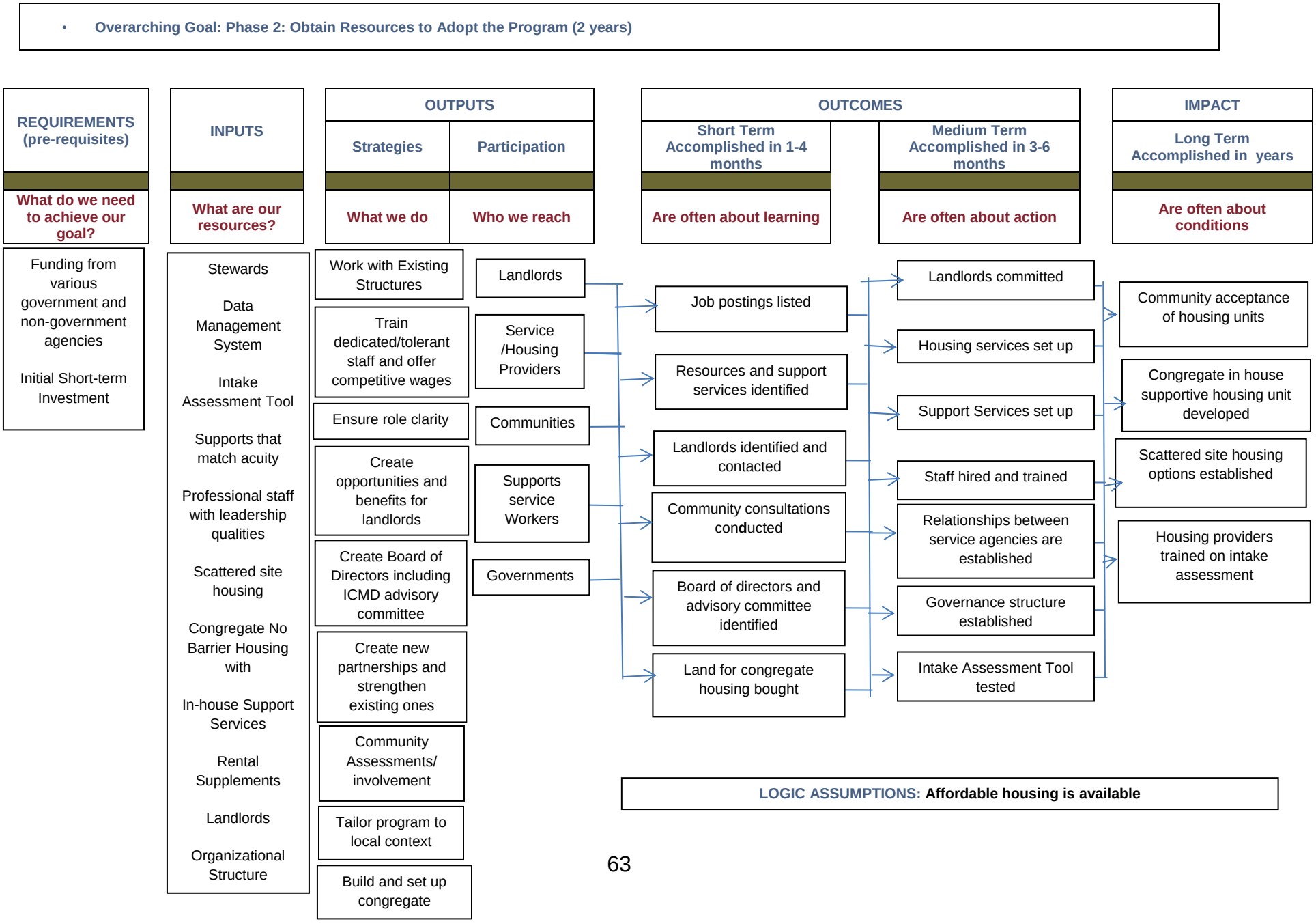
**Partnerships.**Creating new partnerships and strengthening existing ones is also an important factor in implementing HF. As has already been implied, partnerships, including multi-sector partnerships, are key to HF initiatives. Homelessness is a complex problem that requires a coordinated response from multiple sectors to be effectively addressed. Although traditionally homelessness has been the responsibility of the homelessness and housing sectors, health, social services, criminal justice, emergency services, and other human service fields play important roles in eliminating homelessness (Gaetz, 2013b; Nelson et al., 2013). Indeed, many of the challenges homeless persons face in receiving services stem from the complexities in the structure of existing service systems and the difficulties that may ensue when individuals are required to interface with several service providers and agencies (Gaetz, 2013b).

Partnerships are important drivers of HF initiatives. Evaluations of At Home/Chez Soi reported that the key community factors facilitating implementation included the ability of the HF initiative to build partnerships with, integrate itself within, and further build upon, existing service networks, as well as its ability to establish partnerships with government agencies and departments to secure access to housing units, mental health and homelessness services, government income supports, landlords and landlord associations, and community organizations that help deliver and navigate the health care, social services, and criminal justice systems (Nelson et al., 2012, 2013, 2014). In fact, by year three of the four year project, it was perceived that the sense of commitment to, and ownership of the project by the various housing teams, agency partners within the wider mental health and social services systems, and by individuals in the broader community resulted in improved program capacity, greater ability to meet the needs of participants (including greater access to diverse professional services such as clinical expertise, housing specialists, home economists, psychiatric consultants, and vocational specialists), and improved prospects for sustainability of HF (Nelson et al, 2013).

Non-profit agencies, such as HT and CMH that have already established community partnerships, may be ideal for managing HF initiatives. A major strength of PCA was their multidisciplinary teams, the partnerships they developed with community agencies and the range of services, resources, and supports that are offered to their residents. Joint training

among the housing agencies and regular contact with different agencies also helped build connections between community agencies in Vancouver.

***Figure 5*. Phase 2: Obtain Resources**



### 7.1.3 Phase 3: Implement the Program

Once all the resources are in place, Phase 3 can begin by accepting clients (See Figure 6). Phase 3's goal is to implement HF during a trial period of 1 to 1.5 years. Pilot projects, such as conducted in Calgary, have been used to prove the concept of HF, demonstrate it will work in their city, and demonstrate that progress can be achieved quickly through HF (Gaetz& Scott, 2013). It is recommended that the planning and implementation HF should be done in such a way that it allows for successes to be observed quickly and throughout the implementation process, and for disruptions to services to be as limited as possible (Gaetz, 2013b).The assumption of Phase 3 of the implementation model is that a range of housing options and services are available in the community.

Several successful methods of implementing HF models have been reported in Vancouver, Edmonton and Regina and include service support workers acting as a resource, conducting homeless counts, accessing a variety of resources in the community, medication distribution, in-house services in congregate supportive housing units for ICMDs, trusteeship, and utilizing partnerships. Other methods are detailed below.

**Acceptance.**When accepting clients into HF programs, it's important to accept all homeless clients but offer housing to those who need it the most first. In Vancouver, accepting clients who 'best fit' the rooms available in their residence fostered individual needs and was reported as being a strength of the program. CP in Edmonton found that some homeless were 'falling through the cracks'. Therefore, a non-exclusionary approach is recommended. In addition, when accepting clients, a 'no wrong door' approach has been successful in Edmonton and ensuring that the application process is streamlined will help avoid challenges that occurred in Glasgow (Johnsen& Fitzpatrick, 2013).

**Tenancy.**In addition, tenants should sign standard leases that are identical to those that would be signed by individuals living in non-supportive housing implying that tenants are expected to abide by the terms of the governing provincial Landlord and Tenant Act. Finally, there should be no limits placed on clients' length of tenancy and no additional requirements they are expected to meet (e.g., sobriety) beyond the typical terms and conditions of leases in order to maintain their housing (CSH, 2013; Greenwood et al., 2013). In fact, there was very low turnover and longer stays at residences reviewed without limits on the length of tenancy (e.g., PCA).

**Choice.**Choice should be provided at each stage as much as possible.Even if clients are placed in congregate/supportive housing residences, it is still possible to provide clients with some choice such as the unit or floor on which they will live (Patterson et al., 2013). Other strategies, such as regular tenant input meetings, can be integrated into supportive housing residences to provide tenants with more control over what happens in the residence (Scott, 2013c). Such meetings also have the added benefit of helping

program administrators determine what programming is working well and other types of programming that clients think they may benefit from. In general, if clients like the housing in which they live and find that it provides adequate levels of privacy, independence, safety, and quality, they are more likely to remain in the supportive housing unit (Pearson et al., 2007). In Vancouver, housing providers take into account client preferences andthis has been viewed as a strength of the program.

Ultimately, clients should be allowed to choose the type of housing they think will best suit their situation (Gaetz, 2013b) from multiple housing units and the provided choices should reflect different housing models and locations (CSH, 2013). Thus, it is important to keep “the client” in mind as an important variable to consider when matching clients to housing.

**Assignment of support.**Some consideration has to be given to how clients will be assigned to receive service from either the ACT or ICM team. A key component of HF linked to client success pertains to matching the supports available to clients based on their needs and acuity, including their level of psychiatric impairment, during the case management process (Clark & Rich, 2003; Wong et al., 2006). Specifically, a client’s acuity depends on: a) the number individual and systemic issues faced by a client; and b) the severity of those issues. Issues that may contribute to acuity include medical, mental health, addictions, experiences of violence, age, life skills, education, employability, and social supports. Thus, acuity can, and should be, used to determine the appropriate level, intensity, and frequency of case-managed supports that are required to sustain a person’s housing and, consequently, the team that would be best positioned to provide those supports (Gaetz& Scott, 2013b).

In Edmonton, an intake worker completes SPDAT assessments (at the intake and housing stages) to assess acuity. Depending on their acuity he or she may be directed toward market housing, market housing with mobile supports (CAT; ACT), or more structured supportive housing. Ongoing training was found to be important for SPDAT use to increase reliability. Program deliverers using ICM and ACT teams should be aware that there will be some need for the ongoing monitoring clients’ needs, as the level of supports clients require may change over time and the full extent of the clients’ support needs may not necessarily present themselves upon first meeting with the client (Gaetz, 2013b). In fact, this was one of the challenges encountered by ICM teams during the At Home/Chez Soi demonstration project. ICM staff found that many of the “moderate needs” clients referred to their teams actually had a higher level of need that demanded a considerable amount of staff time and required a diverse array of staff skills (Nelson et al., 2012). Moreover, in many cases, it was more difficult to reassign clients to ACT teams after correctly determining their need level than originally anticipated. As a result, by the end of the third year, the ICM teams had come to more closely resemble ACT teams in that they would secure access to specialist resources (such as physicians) and were taking a more

team-oriented approach to case management (Nelson et al., 2013). Not surprisingly, failures to provide adequate support to clients based on their needs and acuity have been demonstrated in the literature to lead to problems with the client and result in precarious housing stability (Gaetz& Scott, 2013). In addition, recurrent homeless substance abusers experienced dips in mood after being housed and staff support was important in dealing with social network changes (Johnsen& Fitzpatrick, 2013).

**Client-centred approach.** One of the hallmarks of HF is client choice. This philosophy should also be applied to the services provided to clients. One of the greatest strengths of PCA was its client-centred approach that fosters individual needs. Clients should have the flexibility to choose the services they wish to receive and be active participants in designing, developing and implementing individualized service plans that are created (CSH, 2013). Any goals that are identified should be realistic, achievable and measureable, and staff should be prepared to regularly update clients' services plans as their needs and goals change.

**Confidentiality.**One challenge that was identified at CP in Edmonton was the lack of information being exchanged between service providers due to privacy rules. At PCA, stakeholder interviews indicated that one of the strengths of the program was that staff may disclose information on an as needed basis to persons and services involved in the health care of the client. Some examples are mental health therapists, licensing officers, mental health housing services, physicians, and psychiatrists.

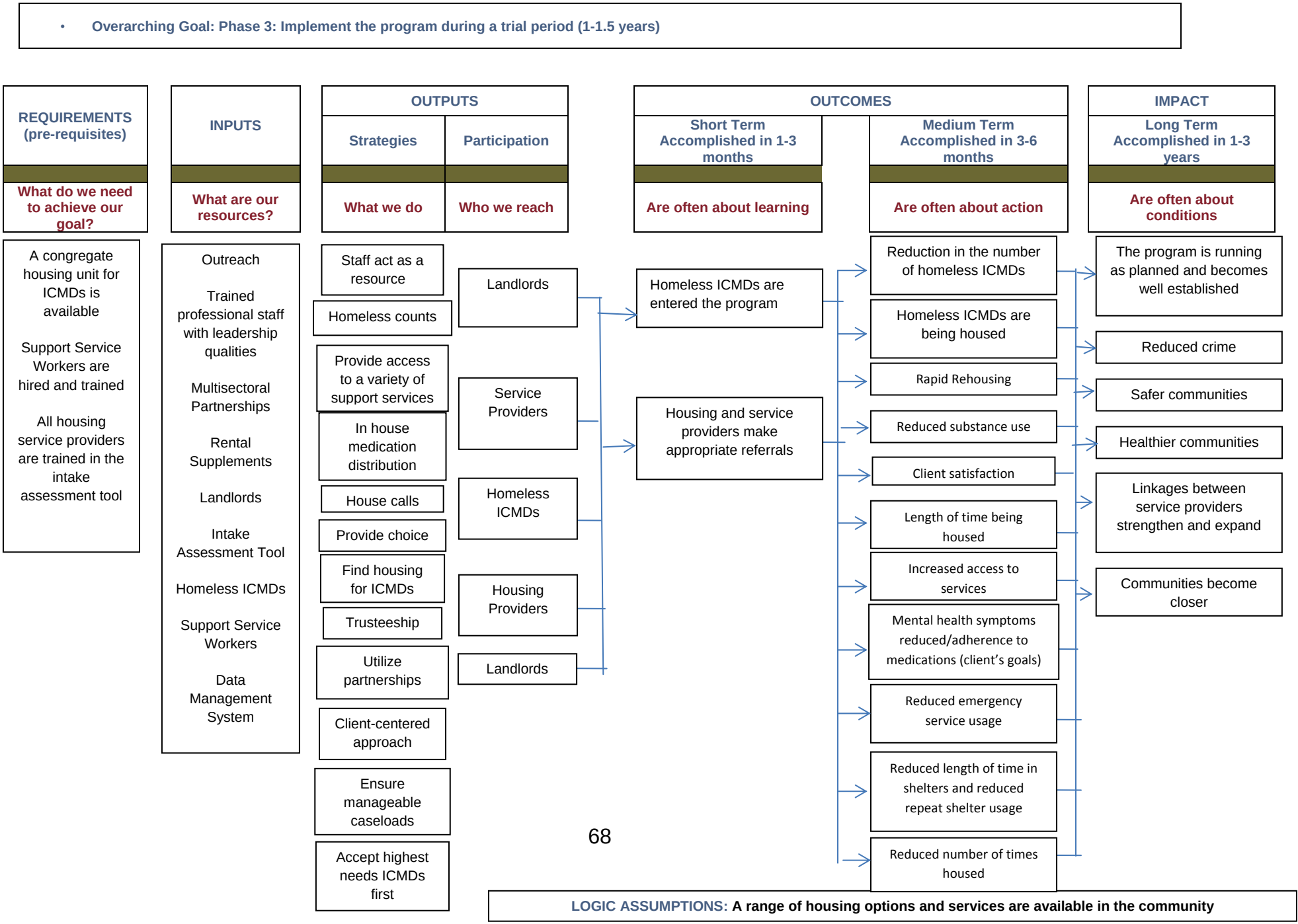
**Staff turnover.**One consistent challenge that was identified at PCA, MM and CP was high staff turnover. Residents in particular found it difficult to build trusting relationships with staff when staff members kept leaving. Stakeholder interviews in Vancouver suggested that turnover may be high due to movement of staff among the different agencies run by CMH and interviews in Edmonton suggested turnover was due to the intensity of the work. Providing a maximum caseload and offering supports to staff may help mitigate turnover. Other case studies provided some suggestions to prevent staff turnover.

The At Home/Chez Soi project revealed a handful of challenges related to staffing that new HF initiatives should be aware of and prepared to encounter. Staff turnover became a challenge by the third year of program implementation. Staff left for a variety reasons, including heavy workloads, pressure to meet project timelines, and concerns about job security (Nelson et al., 2013). If not managed properly, staff turnover has the potential impact program continuity and service delivery. A protective factor that the At Home/Chez project found helpful to avoid some of the negative consequences that may be associated with staff turnover was having strong, stable host agency leadership that could help teams withstand turnover of team leaders. It should be noted that staff turnover is a

common problem in the human service sector and not unique to the At Home/Chez Soi project.

Staff workload issues and caseload size also were identified as major concerns at each of At Home/Chez Soi sites and also at CP. Sites found that their workload was light at the beginning of the project and became heavy (and sometimes excessive) as clients increasingly joined the program (Nelson et al., 2012). Two sites (Vancouver and Toronto) particularly struggled with the great pressure they experienced in trying to keep up with the rate of intake of new clients while simultaneously finding housing for clients, supporting existing clients, and helping them maintain their housing. Similarly, in Montréal, the size the caseload made it difficult to fully adopt a recovery approach because it was not possible to devote the necessary attention (Nelson et al., 2012). In fact, the project changed the ICM caseload ratio from 1:20 to 1:16 (ACT caseloads remained at 1:10) in an effort to mitigate challenges sites were experiencing with caseloads. Another factor that contributed to their heavy workloads included the required travel time to conduct home visits with clients due to their housing being spread out across the cities which consequently made it difficult for staff to achieve a high number of follow-up visits. There is a need to put measures in place to ensure the self-care and well-being of staff (i.e., working regular hours, opportunities to debrief) to mitigate issues associated with workloads and caseloads and help retain staff (Nelson et al., 2013).

*Figure 6*. Phase 3: Implement Program



### 7.1.4 Phase 4: Sustain the Program

The last phase, Phase 4 (See Figure 7) begins once the program has been implemented successfully, is achieving its goals and is cost effective. The goal of Phase 4 is to sustain the program. The length of time for this phase is indefinite. The assumption is that there will continue to be new homeless ICMDs. In order for the program to be sustained over time, the program has to be implemented as planned, funding must be continued and the program has to be effective at reducing homelessness among ICMDs.

**Program monitoring.**First, continued program monitoring must occur to ensure the program is being implemented as planned. Process-related data can be collected which can be used for quality assurance purposes to determine if the HF program implementation is achieving pre-determined standards and is demonstrating fidelity to the guiding principles of HF (Gaetz& Scott, 2013; Rog& Randolph, 2002) and if any adaptations introduced to the program are facilitating or hindering achieved program outcomes (Durlak&DuPre, 2008). Such information also is valuable for improving services, determining where to funnel funds and resources, identifying subpopulations that are being missed, and the particular set of conditions that seem to best facilitate HF in their given community. Together, the process and outcome data will help determine what works, for whom, and under what conditions.

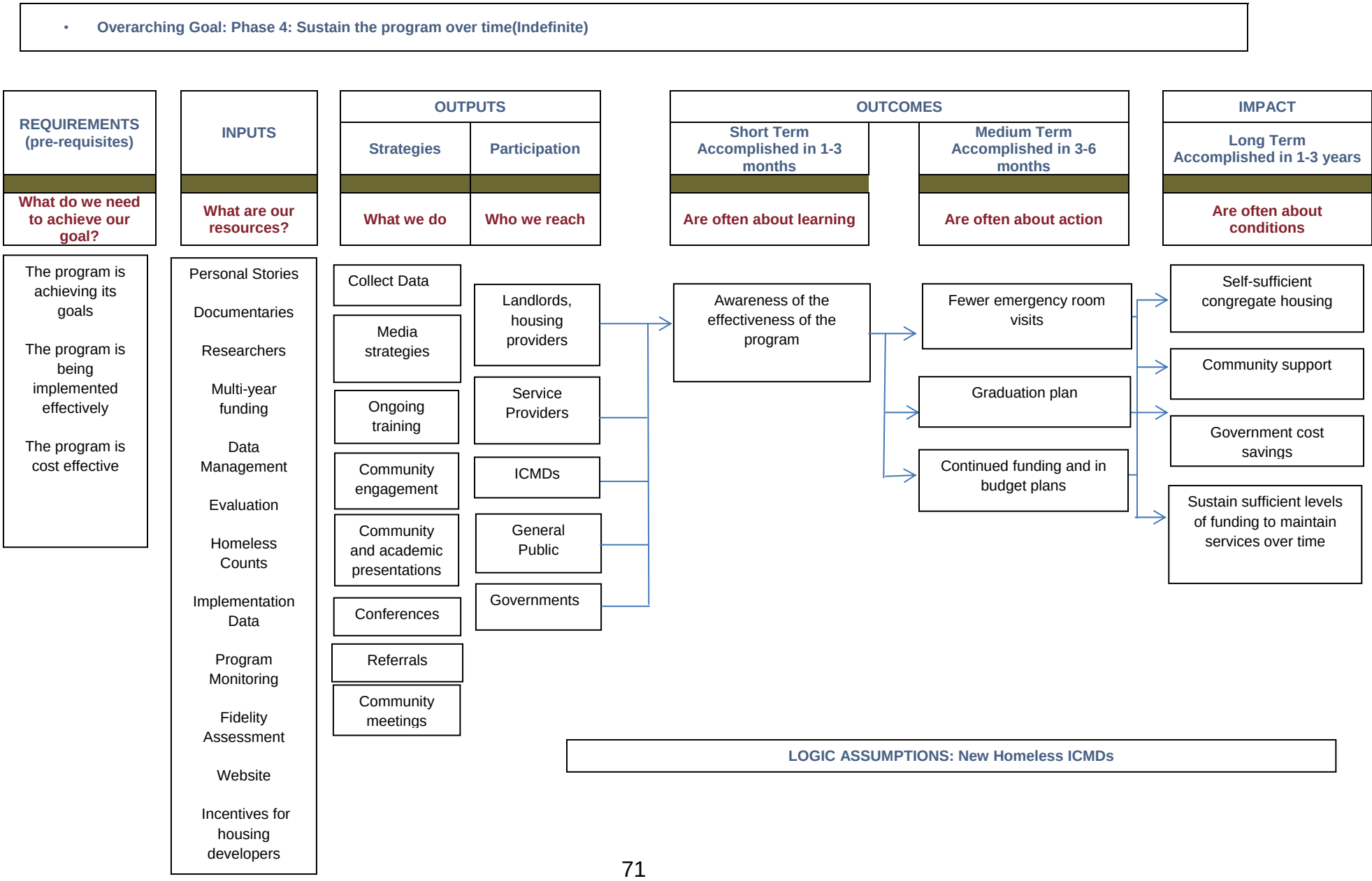
Data monitoring and evaluation systems also have the potential to assist service providers (Gaetz, 2013b). If consistent information is collected about clients, service providers can pull aggregate data in order to obtain information about their clients' characteristics, the outcomes of the services they have provided, and the degree to which their agency is delivering services as intended. In turn, this information can be used to shape services to better meet client needs. At the moment, a consistent method of data collection is not used across sites. Although Edmonton does use the SPDAT, support workers rely on "experiential data" as well as the SPDAT so results can vary depending on the assessor. This example illustrates the importance of proper training when implementing data collection tools.

**Ongoing financial support.**One of the most important factors in the sustainability of the program is continued financial support. One method of sustaining the program financially is to create self-sustaining congregate housing through rents and justify government funding because of cost savings in emergency room visits and shelter usage. Programs must have a plan in place pertaining to how they will sustain sufficient levels of funding to maintain their services over time. Graduation programs can help create new vacancies and save money by helping ICMDs that can become more independent move from congregate housing to more affordable housing units. Depending on when this occurs, HF programs may be able to have funds redirected

toward them that may become available due to decreased demands placed on emergency services (Gaetz, 2013b). However, if not enough time has passed to reap these types of financial benefits from HF, alternative strategies will have to be put in place. McEwen Manor in Regina is self-sufficient and can be used as an example of how to implement a sustainable residence.

**Media strategies.**One method to ensurecontinued funding is to communicate the effectiveness of the program. The media strategies discussed in Phase 1 can be used to achieve this goal; however, now the message being communicated is the effectiveness of the program. Therefore it is important to collect and analyze data and present this information at community meetings, conferences, and in publications. Other important actions that need to continue in order to sustain the program are community engagement, ongoing training, maintaining links to services, developing new services where needed, and providing incentives for building/offering affordable housing for ICMDs.

*Figure 7*. Phase 4: Sustain Program



## 8.0 Implementation of Housing First in Saskatoon: Needs and Feasibility Assessment Results

One aspect of the implementation of HF is to ensure the program is adapted to local contexts. Therefore a needs and feasibility assessment was conducted in Saskatoon in order to apply the model in this city.

The implementation model was applied to Saskatoon to see which elements would be actionable in the local context. Applying the model to Saskatoon as an example can aid future communities to more effectively and efficiently use limited resources. Saskatoon does not currently follow a Housing First Model. CUMFI and the Lighthouse were selected for the Saskatoon needs and feasibility assessment as they provide services, in part, to ICMDs and are located in Saskatoon's downtown or core neighbourhood, placing them at an accessible location for many homeless individuals in Saskatoon. Both organizations, furthermore, own and operate housing in Saskatoon geared towards a variety of clientele where services are incorporated only once the initial housing needs are met. CUMFI and Lighthouse results have been combined here.

*How a Homeless Individual Accesses Housing in Saskatoon*

There is not an established procedure for homeless ICMDs in Saskatoon to access services. Each organization has its own process for accepting referrals, although organizations do refer and communicate with one another in an unsystematic or on a per client basis. As noted in the stakeholder interviews, it can be difficult for clients to access services or navigate the referral process for different organizations.

Most CUMFI residents were previously clients mentored at the CUMFI Wellness Centre. CUMFI does not use a waiting list due to low turnover and Hessdorfer House does not use a strict application process. CUMFI staff already have clients in mind when a suite becomes available. Residents can be referred through probation officers, other clients, the Regional Psychiatric Centre (RPC), acquired brain injury (ABI) referrals or family members. Several CUMFI participants were referred to CUMFI housing internally through CUMFI's Infinity House (*n*=3). Referrals also came from the YWCA shelter, Saskatoon Community Youth Arts Programming (SCYAP), the ABI outreach team—which is an organization that provides support for individuals with acquired brain injuries in Saskatoon (Acquired Brain Injury, n.d.), the FASD Network as well as from family members or partners.

At the Lighthouse, all clients on the complex needs floor (specifically designed for ICMDs) required a professional referral from a psychiatrist, case manager, or other mental health worker. The Lighthouse uses a priority rating scale, accepting clients through a best-fit approach. The referral is sent to mental health and addictions residential services through the Saskatoon Health Region and then brought to a mental health meeting to be

discussed. Those who have the most potential to benefit from the program are accepted as residents. A different referral process is used to place clients in other types of housing provided by the Lighthouse. Often, if a room becomes available, clients that have been utilizing the emergency shelters and appear to have the potential to benefit from supportive services are approached by Lighthouse staff members about their interest in becoming a Lighthouse resident. If clients are not recruited through the shelters, an assigned social worker is able to refer them to the Lighthouse program.

## 8.1 Methods

Interviews with staff and clients were conducted and supplemented by case file information at CUMFI and the Lighthouse, as well as some documents from CUMFI, in order to examine the feasibility of implementing HF in the local Saskatoon context. Stakeholders from the broader community were also interviewed to get a sense of the needs of ICMDs in Saskatoon and feasibility of implementing HF.

*CUMFI*

At CUMFI, staff were interviewed from Hessdorfer House and CUMFI Wellness Centre (CWC). Hessdorfer House is an apartment building where safe, supportive housing is provided for individuals with cognitive disabilities. The CUMFI Wellness Centre provides mentorship, group activities and has a resource centre where clients can shower, use the telephone, write a resume, or find companionship (CUMFI, 2008).Staff experience in their respective positions ranged from 3 months to over 8 years.

Nine clients were interviewed at the CWC and, on occasion, a client's mentor was present. Case file documentation was reviewed for all nine clients and CUMFI documents included CUMFI housing descriptions, the Saskatoon FASD supported housing plan and the CUMFI year-end report.

*The Lighthouse Supported Living*

Four staff members from the Lighthouse were interviewed, including a mental health case manager, front desk worker, support staff/administrative assistant, and the director for communications. Experience working at the Lighthouse ranged from 1.5 to 3.5 years for these staff members.

Ten residents, four from the supportive needs tower (for individuals with addiction and/or mental illness), five from the complex needs floor, and one from the emergency shelter, were interviewed about their experiences as ICMDs who have struggled to find housing, as well as their experiences with being housed and supported by the Lighthouse.

Case file analysis as well as document reviews from the Lighthouse's website were also conducted.

*Stakeholders*

In Saskatoon, seven stakeholders were selected to represent a broad spectrum of housing, service providers, and funders who work with ICMDs and/or who would play a role in implementing HF in Saskatoon. The specific stakeholders interviewed were identified through a community consultation process that was held by the United Way in May, 2013. Interviews with stakeholders were conducted at their respective organizations.

### 8.2 Program Descriptions: CUMFI

CUMFI is a Métis owned and operated community-based, non-profit and charitable organization in Saskatoon. CUMFI was founded in 1993 "to ensure that the voice of Métis people is heard at the municipal level within Saskatoon and district" (Saskatoon FASD Supported Housing Project & Central Urban Métis Federation Inc. [FASD & CUMFI], 2007). The voluntary Board of Directors works towards improving the social and economic status of Métis people in Saskatoon, and to build positive community relationships (FASD & CUMFI, 2007).

An organization of approximately 6000 members, CUMFI provides a variety of services, including drug and alcohol-free housing to the inner city community of Saskatoon (FASD & CUMFI, 2007). CUMFI recognizes that FASD is a factor in the lives of many Saskatoon Aboriginal individuals, and other members of the Saskatoon community and provides services that focus on the needs of individuals with FASD, ABI or other types of cognitive disability such as:

- Mentoring (individualized support for persons who live in a variety of housing situations)
- Drop-in Centre (at the CUMFI Wellness Centre)
- Supportive Housing (Hessdorfer House)

The goal of services offered by CUMFI is to provide support to individuals with challenges and assist them in achieving personally satisfying, healthy lifestyles and express their strengths, while focusing on community inclusion.

In 2000, CUMFI created a Community Advisory Committee comprised of a membership at-large to provide advice and to oversee the implementation of CUMFI's housing strategy. CUMFI's Housing Strategy focuses on a continuum of care where clients are assisted in moving from transitional housing to affordable housing (FASD & CUMFI, 2007). Table 4 lists the housing options provided by CUMFI.

Table 4: *Housing Options Provided by CUMFI*

| Housing | Description | Staffed | # of units |
|---|---|---|---|
| **Hessdorfer House** | Safe, supportive housing for individuals with cognitive disabilities | House parent | Apartment building with 5 suites<br>Three 1-bedroom suites (1 for the house parent)<br>One 3-bedroom suite<br>One 2-bedroom suite |
| - Shelter clients are referrals from the Ministry of Social Services (MSS)<br>- Clients can be placed in 1 of 3 shelters based on their individual assessment<br>- Shelters are monitored and staffed 24/7 and offer a variety of supports to clients | | | |
| **Infinity House (Est. March 2002)** | Transitional and emergency housing for high risk female single parents in times of crisis<br>Common area and resource room for children<br>An Aboriginal-owned and operated facility that reflects Aboriginal values and beliefs<br>Clients need to comply with numerous conditions to progress through different transitional forms of housing (e.g., sober from 6 months to 1 year) | Has counselling and support services<br>Outreach services to clients who have moved back into the community<br>Teams of 1 male and 1 female conduct home visits between 1:00-9:00 pm. | Each family has their own apartment<br>16 suites<br>4 emergency suites<br>12 long-term suites<br>1 resource room/1 counselling office<br>Houses 14 families |
| **2. a. Kanawey-imik** | Low risk home for single women who may be at risk of having their children placed in foster care<br>Tenants have more independence than Infinity House | | Each family has their own suite<br>12 apartments |
| **b. (NIWA) Niwaapatah-anannik (Re-structuredJuly, 2012)** | For single males, children, and couples<br>Seen as a progressive move<br>For those with children in foster care or at risk of having children in foster care<br>Helps families who are homeless or on the verge of | | 11 suites |

| | | | |
|---|---|---|---|
| | homelessness<br>Visiting suites: A place where families can have supervised visits with children in foster care | | |
| **McLeod House (Opened April, 2004)** | For men recovering from addictions<br>No children<br>Offers support services and programming for men post-treatment and recovery<br>Referrals from community support organizations | Staffed 24/7 Monitored | 12 suites<br>Can house 16 single men<br>Transitional housing |
| **Affordable Housing** | Zero tolerance of alcohol, substance abuse and violence<br>Affordable rent<br>Located in Pleasant Hill community, same as CUMFI shelters, so shelter clients can continue to access support programs in the community | | 4 apartment buildings<br>64 suites total: 31 suites, 11 suites, 12 suites and 10 suites respectively<br>One and two-bedroom suites<br>Several amenities available (security services, playground, etc.) |
| **Kokum's House** | Temporary<br>Provides safe haven for children and families | | Safe and secure home |
| **Housing for families affected by HIV** | Offers housing and support for parents with HIV and their children | Not on-site CUMFI outreach | Older, by-level house<br>2 fully-furnished suites |
| **Emergency Placement Program** | Provides temporary shelter for a family whose children are at risk of going into the care of the Ministry<br>Designed to preserve the family unit | Community workers provide one on one support to families | |

(CUMFI, n.d.)

It should be noted that while each type of CUMFI housing does accommodate some individuals with dual diagnoses only Hessdorfer House has been specifically set-up for that purpose.

### 8.2.1 Demographic Profile of ICMDs at CUMFI

Nine (5 male and 4 female) participants were interviewed with a mean age of 42 years. Six participants were Aboriginal, two were Caucasian, one was not specified. Some participants lived in multiple CUMFI housing residences, including: CUMFI affordable housing (*n*=4), Hessdorfer House (*n*=3), Infinity House (*n*=2). Other participants had never lived in CUMFI housing, but had accessed their services as a client. Three participants were married and three were single/never married. One was separated (common-law), one divorced and another's status was unknown. Five participants had children, and one had several step-children. Of these participants, one had none of her children in her care, and one participant had one child in her care. Most participants had an education ranging between grade nine and grade eleven (*n*=6). One participant had a high school diploma or equivalent and another had a college or university certificate/diploma. Participants utilized a variety of income sources: Saskatchewan Assured Income for Disability (SAID) (*n*=7), Saskatchewan Rental Housing Supplement (SHRS) (*n*=4); child tax credit (*n*=2); residential school settlement (*n*=1) and one received mental health approved home rates. Most participants were primarily in control of their own income (*n*=5); two had joint control with their wives and one with his mother. One participant had a public trustee who would give money to his mentor on a monthly basis.

Overall, six of the CUMFI participants were ICMDs. Those who were not diagnosed, suspected by staff or self-reported to have a substance abuse or dependence disorder, suffered instead from multiple mental disorders (*n*=3). Participants recently or currently used marijuana (*n*=2; occasional use, *n*=1) and Tylenol (*n*=1; time of last use unknown). Four participants were diagnosed with or self-reported an alcohol abuse or dependence disorder and another participant drank occasionally. Participants were also diagnosed, suspected by staff or self-reported having the following mental disorders: FASD (*n*=6); PTSD (*n*=4); intellectual disability (*n*=3); anxiety (*n*=2); ABI (*n*=2); bi-polar (*n*=2); depression (*n*=1); head injury (*n*=1); complex learning disabilities including dyslexia (*n*=1); delusional (*n*=1); and kleptomania (*n*=1).

Participants had physical health conditions in addition to their mental health conditions, including: epilepsy/ seizures or seizure disorder (*n*=2); diabetes; hip dysplasia; thyroid condition; allergies; stomach upsets, heart rate, chest pains and asthma (due to anxiety and anxiety attacks), arthritic knee; hernia; and annual pneumonia or bronchitis. In addition, eight participants had been hospitalized, three while they had been residents of CUMFI. One participant had taken three trips to emergency for anxiety attacks (but had not been hospitalized) and another participant had been hospitalized twice while a client of CUMFI. Reasons for hospitalization were: childbirth (*n*=2); hip surgery, serious blood infection; struck by a car; serious brain injury; seizure; and serious accident causing spinal damage. In terms of participants' level of functioning, CUMFI case files provided

information on participant's life skills, budgeting skills, health and safety behaviours and interpersonal relationships (See Table 5 below).

Table 5: *CUMFI Participant Information*

| Participants' skills/ areas of functioning | Participants' abilities | Further information on participants' abilities |
|---|---|---|
| **Life skills/daily activities** | Housekeeping skills<br>Good (*n*=5)<br>Poor (*n*=3) | Supports are helpful as in at least three cases, functioning is cyclical or can vary according to mood, medication or motivation. |
| **Budgeting skills** | Money management<br>Difficult (*n*=3)<br>Variable (*n*=3)<br>Generally good (*n*=3) | Participants whose money management is "variable" generally had good money management except when being affected by their addictions or being exploited/taken advantage of by others.<br>Having a mentor help with money management or having money paid directly to the residence for food or rent proved to be helpful to some clients (*n*=3). |
| **Health and safety behaviours** | Did not acknowledge mental illness/ does not like taking medications (*n*=3)<br>Functioned well with regards to health and safety (*n*=2)<br>Did not understand why behaviours were dangerous (*n*=1)<br>Substance or alcohol abuse interfered with the return of children from foster care (*n*=2) | CUMFI has helped some participants (*n*=3) manage their substance/alcohol abuse through treatment or community addiction classes.<br>For one participant struggling with the return of children from foster care due to alleged alcohol abuse, CUMFI had never seen her drink in the seven years they had worked with her. |
| **Interpersonal relationships** | Difficulty conversing with others (*n*=3)<br>Tended towards physical, emotional or verbal abuse (*n*=3)<br>Too trusting/taken in by strangers (*n*=1)<br>Capable but tended to alienate others (*n*=1)<br>CUMFI helped clients build relationships (*n*=5) | Some participants were able to overcome difficult interpersonal relationships or situations by avoiding certain friends or not socializing at night (*n*=2).<br>CUMFI helped build relationships through a continuum of support (*n*=1); by building a sense of community or trusting relationships with others (*n*=2); or, by working through issues with the support of mentors (*n*=6) or a psychiatrist who visits CUMFI every second week (*n*=1). |

### 8.2.2 Successes and Barriers

*Success: Effective Supportive Housing Methods Used at CUMFI*

Staff interviews and the document review revealed several successes at CUMFI such as having a range and variety of supports offered to clients. These success are outlined below.

**Access to programs and services.**CUMFI has its own vans or provides transportation for most programs. CUMFI also offers assistance to people who need help accessing and maintaining services and opportunities in the community.

**CWC Creative Solutions Fund.**The CWC Fund creates opportunities for clients to express strengths and avert crises. For instance, money from the Creative Solutions Fund could be directed towards replacing a drivers' license or purchasing gym clothes to enable a student to attend gym class.

**CUMFI housing and CWC services.** CUMFI's housing and Wellness Centre provide a variety of other services, such as:

- Trauma counselling that is available on a daily basis.
- Having a psychiatrist hold clinics at the CWC (a setting with which clients are comfortable) every second week.
- Assistance with prescriptions.
- Addiction counselling for women of childbearing age available through Saskatoon Health Region in the CUMFI building.

CUMFI's yearend report also mentioned the following strengths or factors that they consider to contribute to positive outcomes

**Relationship-based service**. CUMFI's focus on building relationships with each individual client contributes to clients' positive outcomes. This relationship-building includes the advocacy that mentors provide to their clients.

**A focus on client strengths.**CUMFI takes note of clients' strengths and searches for opportunities such as volunteering or recreation for clients to express these strengths.

**Support for justice-matters.** In the past, when there was a greater need, there was a designated justice worker at the CWC.

**Providing a continuum of services.**CUMFI mentors connect clients to a continuum of services and resources in the community, and can complement or fulfill areas where there is a gap in service provision.

**Elders and traditional culture.**A Métis elder is at the CWC resource room weekly and has cultivated many positive relationships with clients. First Nations Elders are also

involved and all Elders provide support, understanding as well as share their stories and wisdom.

Interviews with clients outlined a number of things clients liked about CUMFI, describing it as nice, beautiful, cool, comfortable, fair and clean. Clients also liked the following CUMFI characteristics:

**Mentor support.**Many clients spoke of the help received from one mentor in particular, demonstrating the impact that a mentor can have on clients.

**Safe environment.**One client mentioned that he liked having the Wellness Centre to go to in the day, instead of the streets. Some also said that CUMFI feels like family or community and appreciated that it has a low tolerance to disobeying the rules**.** Some clients also liked that CUMFI was alcohol and drug-free.

*Challenges and Barriers*

Staff highlighted some of the challenges and barriers specific to housing in Saskatoon.

**Wide-open mandate**. Not following a strict guideline of who can be helped by CUMFI is positive as there is flexibility to be able to help someone who needs it. On the other hand, not saying “no” can cause strain on the organization and the individual workers in that organization.

**Conditional support.** One challenge in Saskatoon is the conditional support that is offered to some clients. When one client proved challenging, her mental health worker intended to close her file.

**Lack of supports for young men.**Supports in Saskatoon are focused on women and children**.** Young men, as a result, become dependent on mothers or partners for access to housing**.** It is difficult, as well, for young men to gain responsibility for children.

**Youth who fall through the cracks (homeless 17 year olds).**An integration plan is needed for youth. Youth leaving the foster care system need support acquiring housing. Housing requires individuals to be 18 years old and have landlord references and some youths are expected to leave home when their child tax is terminated at 18.

**Furnished apartments.**Furnished apartments are desirable for those who have no furnishings but problematic for those who have furniture that they cannot use**.** Social services will only pay for furniture in a grant once so when people move out they are not able to get furniture again**.**

**Putting out fires.**Staff spend a lot of time responding to crises which means that they are less able to work proactively towards CUMFI goals. As noted in CUMFI’s 2012-2013 report, training can contribute to a feeling of renewal among staff who experience the burden of responding to these crises.

**Staff working past hours.**The Wellness Centre closes at 5:00 pm, but clients’ needs exceed working hours. In the CUMFI year-end report, however, staff accessibility is

considered to be a factor that contributes to positive outcomes. Having staff working regularly with flexibility in scheduling and each having a cell phone, allows staff to be available when it is necessary in evenings and weekends.

**Rental supplements.** Requirement of damage deposits and first month's rentcan be problematic for clients.Social Assistance can only guarantee a damage deposit equal to the shelter rate, not equal to the first month's rent**.** Disability rental supplement has had a positive impact on CWC clients, but clients have to be living in a residence and provide proof that they have paid the rent in full to be eligible for the supplement. As such, it is difficult for clients to pay the first month's rent. The supplement is dispensed at the end of the month, so it can be received too late for some clients to pay their rent (one client has been evicted more than once for this reason) (CUMFI, 2013).

**Emergency housing.** CUMFI had attempted to provide emergency housing to the Saskatoon community, but it was discontinued due to insufficient funding (as well as the following reasons: not staffed overnight, clients had not established connection to CUMFI and it was chaotic).

There were also a number of challenges focused on the Saskatoon context that were highlighted in CUMFI's 2012-2013 yearend report. Mentioned here are some that were not addressed in the staff interviews or in other sections of the report:

**Funding.** A challenge identified in the document review was that CUMFI encounters difficulties funding its programs and services. Government grants are provided only for an intended purpose and do not cover the complete cost of program operation. As such, CUMFI must make up the difference by locally raised funds.

**Restricted counselling services.**Counselling is available to clients with First Nation status and then only short-term on an emergency basis. Interviews with staff also noted the difficulty of knowing the clients' status.

**Residential school hearings.**The anxiety of residential school hearings and their effect on clients' mental health, as well as the difficulties with finding support and interacting with legal representation that is distant and aloof was also noted in the report.

**Lack of references.**Clients who have been "couch surfing," homeless, living with families or in the foster system do not have the two required references to access rental properties. Along with high rents and the requirement of damage deposits, lack of references is a barrier to clients finding housing.

**Trusteeship.**The availability of trustees in Saskatoon is positive; however, it is generally a situation that clients enter with much contention and reluctance. On the other hand, a client's poor money management skills in tangent with easy access to credit or goods purchased through rent-to-own schemes can contribute to debt that clients cannot pay off.

**The justice system.**Clients with FASD or other cognitive disabilities can find themselves in the justice system due to poor judgement, poverty, addictions, vulnerability or manipulation and can continue to have difficulty in the system due to a number of these factors which may contribute to a breach leading to longer incarceration and more punishment.

**Casual or intermittent support and respite.**Also flagged as a need by CUMFI was for clients to have access to services beyond what mentors can offer in terms cleaning or help organizing their home and trustworthy childcare in order to attend appointments or have personal time. This could also mean simply spending time with a client who needs occasional supervision for safety purposes.

Client interviews, supplemented with information from the CUMFI yearend report and staff interviews revealed a number of challenges and barriers that clients face when renting in Saskatoon, such as:

**Landlord accountability.**Landlords are not necessarily accountable to anyone who requires them to make necessary repairs or address tenants' concerns. One client noted that she was taking landlords to court and winning. When she went through the rentals ombudsmen, and when they sided with her on landlord wrongdoing, she still only had the power of recommendation.

**Paradoxical housing and funding requirements.**Clients need their children to obtain particular housing, but also need housing to get their children. The same is true for rent and the Disability Rental Supplement (DRS): clients need to be housed to receive the supplement, but have difficulty paying for the rent required for the first month without first having the supplement (CUMFI, 2013).

**Finding the right fit.** Client interviews demonstrated the importance of finding the right housing fit for a client. A good housing fit can be the difference between feeling a sense of community or exacerbating current challenges and destabilizing a family. However, in Saskatoon the ability to find the right fit is tempered by high rent and landlord discrimination towards clients based on income, for example.

Clients also had some complaints particular to CUMFI, specifically regarding:

**Inflexible rules.**Some clients mentioned there being a curfew rule, which they found too strict, especially those who had to work later than the curfew.

**Less freedom and independence.**One client mentioned feeling scolded by CUMFI for personal choices. Another client felt that CUMFI had pushed her into counselling she did not want**.** One client felt that CUMFI was too involved in her relationship with her partner**.** Some clients found CUMFI programming too structured.

### 8.2.3 How CUMFICould be Adapted to Meet the Needs of ICMDs within a Housing First Model

CUMFI strives to operate within a HF approach. There are two possible routes that can be taken to further incorporate CUMFI into a HF approach. The first would be to maintain CUMFI's current model of functioning and have it represent one option among others, in a larger HF system, for clients to choose from when selecting housing. The second would be to make changes to CUMFI 's current structure in order for the organization itself to reflect many more of the main characteristics of HF. Taking the first route, even without any changes, CUMFI can be one housing option for clients who need or can comply with a drug and alcohol-free environment.

If CUMFI were to be incorporated into a HF model via the second route, CUMFI already has many strengths. For example, CUMFI has adopted a recovery orientation in which clients are provided services, support and opportunities for social and community integration (e.g., a drop-in centre) and clients are provided individualized support through mentoring that nurtures their strengths. An important aspect of implementing a HF initiative is providing the appropriate training to service providers. Staff members have received specialized training in order to work with CUMFI clients. CUMFI also provides several opportunities for socialization and community integration. These opportunities include, among other things, a resource centre and an innovative form of funding individuals (using the CWC Creative Solutions Fund), so that they may participate more fully in activities and in their communities. However, a number of other changes would still need to occur for CUMFI to adopt more fully the core principles of a HF approach.

One of the most important changes that would need to occur for HF to be implemented in Saskatoon is immediate access to housing with no housing readiness requirements. CUMFI has long waitlists with low resident turnover as well as a requirement for abstinence. Most ICMDs will not be abstinent, and if they are, they may be at risk of relapsing, which may lead to eviction and homelessness. More rooms would also need to be made available for ICMDs who need them most. One method of ensuring that a room is available is to only accept high acuity clients who need the housing the most and to regularly check to see if clients would like to move to less supportive housing. In addition, all ICMDs should be accepted regardless of whether they are current users or not. CUMFI does not adhere to a harm reduction approach in this manner, as many of its residences are drug and alcohol free. Abstinence-only residences may be preferred by some clients and should be one available option in a HF system, but harm-reduction residences should also be an option. In the larger context of the city, accepting that clients may be using and using a harm reduction approach may increase addiction services and supports available.

Another issue, that would also be a problem in the adoption of HF in Saskatoon more generally, is client choice and self-determination. Having clients apply to each

residence separately coupled with low vacancy rates means that clients do not have much choice in where they are housed. A ‘no wrong door’ approach (coupled with more housing options) where they could enter the system and be placed in a residence of their choice would be more consistent with HF. A systematic approach should be established for accepting ICMDs and placing them in the appropriate housing of their choice. In addition, some clients at CUMFI complained about trusteeship, the rules at some of the residences and about feeling a lack of freedom and independence. To emphasize choice, programs should be an option, not a requirement within a HF model.

### 8.3 Program Descriptions: The Lighthouse Supportive Living

The Lighthouse Supportive Living Incorporation is located in downtown Saskatoon in what used to be a hotel. The Lighthouse is a community based non-profit organization that is committed to caring for the poor, marginalized, and hard to house individuals of Saskatoon. The Lighthouse’s minimal vacancy rates, long waiting lists, and overflowing emergency shelters are indicative of a higher need for more affordable and accessible housing in Saskatoon.

The Lighthouse has a men's shelter (20 beds), a women's shelter (17 beds) and a stabilization unit (20 beds) that accepts intoxicated individuals. In 2012, the Lighthouse opened up 58 affordable housing suites built beside the original structure. Individuals with addictions and/or mental illness occupy the supportive living tower, which provides access to 24/7 front desk services, supports, and a meal program. In 2011, the Saskatoon Health Region provided $170,000 for renovations and upgrades to the first floor of the supportive living tower. Nine rooms now occupy the first floor, 8 of which are considered complex needs rooms and are occupied by residents with concurrent disorders that have struggled to maintain housing in the past. Complex needs clients are limited to a one year stay on this floor as it is considered to be a transitional program. Clients are required to work with a case manager who is on site five days a week, attend two programs offered by the Lighthouse each month, and comply with medication dosage and instruction. The ninth room is a respite room available for emergency stays up to two weeks in length.

The addition of an affordable living tower at the Lighthouse provided more space for a common lounge area. The lounge is available to all Lighthouse clients and includes a secure storage area, a personal needs room equipped with everyday amenities such as showers and toothbrushes, a telephone, and internet access. An improved kitchen, classroom, meeting rooms, and nurse’s station have also been added.

*Lighthouse Rules and Expectations*

Clients must be a minimum of 16 years of age to use any of the Lighthouse facilities. The Lighthouse is a drug and alcohol free building; however, these rules are not strictly enforced, as the supportive living tower is a long-term housing option and considered a

private residence. Complex needs clients at the Lighthouse are required to follow more specific rules that are strictly enforced. These rules include proper compliance to medication instructions, working with a case manager on a weekly basis, and attendance of at least two recovery programs a month. Room checks are also conducted on a daily basis to regulate substance use and cleanliness. Inability to comply with Lighthouse rules or pay rent results in eviction. If a resident is causing a disturbance in the building and refuses to calm down or leave the premises, the police may be called for assistance.

*Programming*

Regular programming, originally developed for complex needs residents, is open to all Lighthouse residents and includes recovery classes such as assertiveness training, anger management, Alcoholics Anonymous, and stress and self-care classes, as well as leisure classes such as sewing, cooking and game night. Staff members consider recovery classes that address addictions or mental illness as the most effective at supporting ICMDs. Daily routine and class consistency is considered a vital ingredient to the success of complex needs clients and is reflected in structured programming and regular room checks. Staff also noted that classes become more effective the longer clients reside at the Lighthouse due to daily structure, comfort utilizing support services, and skill improvement. While regular attendance can be difficult to promote to most Lighthouse residents, programs that provide food to attendees have much higher attendance rates.

Through their experience working at the Lighthouse, staff members indicated that ICMD residents need: structure and consistency with meals, medications, and appointments, basic life skills training, medical and mental health staff nearby and available, and feelings of dignity and respect. Staff also identified that this population needs help navigating the housing system in Saskatoon. This includes assistance with paperwork, landlord references, locating money for a damage deposit, and clear communication with potential landlords.

### 8.3.1 Demographic Profile of ICMDs at the Lighthouse

Ten residents from the supportive needs tower and the complex needs floor were interviewed about their experiences as ICMDs who have struggled to find housing, as well as their experiences as clients being housed and supported by the Lighthouse. The average age of the residents interviewed was 34 years; there were 4 men, 4 First Nations residents, and 4 Métis residents, as well as 1 Pakistani and 1 German resident. All participants reported at least one mental health disorder including: schizophrenia (*n* =4), depression (*n*=3); anxiety (*n*=3); PTSD (*n*=2); bipolar (*n*=2); ADHD (*n*=2); FAS (*n*=1), brain injury (*n*=1), suicidal ideation (*n*=1), eating disorder (*n*=1), and personality disorder (*n*=1). Of the clients interviewed, 7 reported substance use including cocaine (*n*=4), marijuana (*n*=3), morphine (*n*=2), crystal meth (*n*=2), and crack (*n*=1). Five participants reported

alcohol use and two participants were recovering addicts, one of whom was currently on methadone.

Participants previously lived in a variety of housing situations. Seven had lived in group homes, one in affordable housing, three in approved homes, four in shelters, and one on the streets. Of the places they had lived in the past, three preferred to live in group homes, one in approved homes, one on the street, and one participant specifically identified the Lighthouse. Participants reported their best experiences involved living in a home with a family-like atmosphere, including feelings of love and acceptance and group activities such as eating together around the dinner table. Other reasons participants liked living in certain places included enjoyment of a front yard or lawn, lack of rules, feelings of independence and self-respect, and a general sense of security. In terms of the accommodations participants liked living in the least, two reported group homes, one a rental house because of drug abusing roommates and dirty living conditions, one in approved homes, two with family due to lack of independence and crowding, and two specifically disliked Mumford house because they disliked living with children or had their personal belongings stolen. Other reasons participants disliked previous housing included having to adhere to too many rules, bad food or not enough food at mealtimes, being bullyied by the head of house or tumultuous relationships with other tenants. Participants also disliked living situations in which they were treated as a “paycheck” by those who were supposed to provide support.

### 8.3.2 Success and Barriers

*Success: Effective Supportive Housing Methods Used at Lighthouse*

Residents were asked what they liked about living at the Lighthouse. The most common responses are listed below.

**Staff.** When asked what they liked about living at the Lighthouse, the most common responses were the friendly, caring, and welcoming staff.

**Independence.** Many residents also reported liking the sense of independence living on their own provided them.

**Space for social interactions.** The mix of personal and public space for social interactions helped prevent residents from isolating and provided them with the opportunity to make good friends.

**Security.** Residents felt a sense of security resulting from 24-hour staffing and security cameras.

*Challenges and Barriers*

Residents cited various challenges they had personally experienced in their attempts to find and maintain housing. A history of involvement in the justice system, with mental illness, or with substance use made finding a house difficult, especially when so few options exist in Saskatoon. Discrimination was also identified as being rampant towards Aboriginal persons, decreasing chances of finding housing even more among this population. Many residents struggling with addiction discussed experiencing a lack of motivation to continue the search for safe housing when using.

Under the influence, residents noted that their priorities changed from the search for basic necessities to the search for their next high. Continuous drug use also led to poor memory, attention span, and concentration in some users. This often resulted in an inability to maintain work, missed appointments, dirty or messy living conditions and an inability to pay bills. Because this population is so transient, many individuals struggling with homelessness do not have government identification or proper rental histories. All of this creates a situation ripe with discrimination and results in severe impairment in ICMDs' capacity to access the housing system.

Staff and clients identified numerous areas in which they believed the Lighthouse could improve.

**Building structural problems.** The common suggestions for improvement were a result of the building's structural problems such as a lack of hot water or inconsistent heating within the building.

**Bedbugs.** Bedbugs have been a common problem and some participants suggest ridding the building of carpets to remove bedbug infestation.

**Favouritism.** Instances of resident favouritism by various staff members were reported.

**Stronger enforcement of no drug policy.** Some participants suggested stronger enforcement of the no drug policy, as many residents struggle with their own addiction problems. The close proximity of the stabilization unit has presented similar issues, creating a situation in which intoxicated individuals are near those attempting to abstain or reduce their contact with these substances.

**Access to addictions counselling.** While addictions counsellors can be found working with clients at the stabilization unit or on the complex needs floor, many residents in the supportive housing tower feel they would also benefit from professional addictions counselling.

**Need for more supportive living suites.** The high usage of both shelters and the stabilization unit has increased awareness of the need to provide more supportive living suites.

**More indoor activities.** One participant suggested there be more indoor activities such as games during the colder months when spending time outdoors was more difficult.

**Improving meals.** A common suggestion for improvements involved food, such as preparing healthier options (e.g., less deep fried food or pork) and increasing the portions of each meal.

### 8.3.3 How the Lighthouse Supportive Living Could be Adapted to Meet the Needs of ICMDs within an Housing First Model

The Lighthouse Supportive Living residence meets the needs of ICMDs by providing eight rooms specifically for clients with concurrent disorders who have struggled to maintain housing in the past. The Lighthouse fits into a HF model because it provides access to 24/7 front desk services, supports, and a meal program. In addition, the Lighthouse has a recovery orientation by providing regular programming that includes recovery classes, such as: assertiveness training, anger management, Alcoholics Anonymous, and stress and self-care classes, as well as leisure programming such as sewing, cooking, games night, and a coffee house.

There are also other opportunities for social and community integration. There is a common lounge area available to all Lighthouse clients as well as a kitchen, classroom, meeting rooms, and a nurse's station. The Lighthouse uses a priority rating scale, accepting clients into its complex needs suites through a best-fit approach. Those who have the most potential to benefit from the program are accepted as residents. To ensure that rooms are available to ICMDs who have chosen to live at the Lighthouse, and who need it the most, the program should continue to use the priority rating scale.

The Lighthouse could represent a housing option amongst others in the context of a larger HF system. The organization itself, however, could also be modified to better meet the needs of ICMDs and adopt more characteristics central to a HF model. For instance, although the Lighthouse provides a number of services and programs, some of these programs could be less restrictive and provide more options. For example, some clients indicated that more indoor activities were needed especially during the cold winter months (others, however, tended not to attend programming) and that some services were restricted to specific clients. More specifically, interviews indicated that some residents in the supportive housing tower would like access to addictions counselling, which is currently only available to residents at the stabilization unit or on the complex needs floor.

As mentioned previously, an important change that would need to occur for HF to be implemented in Saskatoon is access to housing without readiness requirements. Since the

rules regarding drug and alcohol use are not strictly enforced, as the building is a long-term private residence for individuals, the Lighthouse staff might consider eliminating these readiness requirements. Since some residents abstain from drugs and/or alcohol, having either a drug/alcohol free floor or a “currently using” floor would provide residents with options. In addition, a central characteristic of the HF model is the provision of permanent housing. Currently, ICMDs at the Lighthouse are limited to a one-year stay on the complex needs floor as it is considered a transitional program. By becoming a permanent rather than a transitional program, the Lighthouse would better fit a HF model. The Lighthouse does have a stabilization unit (20 beds) that accepts intoxicated individuals, which fits a harm reduction model; however clients can only stay at the stabilization unit overnight (4:00 pm – 8:00 am) (Hamilton, 2013). In order to extend the harm-reduction model, this stabilization unit could branch-out and become a long-term residence as well.

Another important aspect of HF is providing appropriate training for service providers to work with ICMDs. Currently, the Lighthouse does not provide specialized training for staff members who work with ICMD residents. If the Lighthouse were to be integrated into a HF model, staff members would need to attend specialized training opportunities.

Finally, finding ways to increase residents’ choice in services and programs provided to ICMDs should be examined at the Lighthouse. For example, ICMDs living in the supportive living tower are required to work with a case manager on a weekly basis, attend two programs offered by the Lighthouse each month, and comply with medication dosage and instruction.Complex needs clients living on the complex needs floor are required to follow even more specific rules that are strictly enforced. While following these requirements will work very well for some ICMDs; they will not work well for all. A consideration of individualized program needs could be beneficial.

### 8.4 Stakeholders’ Perceptions of Housing First for ICMDs in Saskatoon

Stakeholders from the following organizations were interviewed at their respective offices: Saskatoon Housing Coalition, the City of Saskatoon, Stewart Property Holdings, Saskatoon Health Region– Mental Health and Addictions, Saskatoon Housing Initiatives Partnership (SHIP), the Bridge and the Canadian Mental Health Association – Saskatoon Chapter. Along with stakeholders, four staff members from each CUMFI and the Lighthouse were interviewed and asked more broadly about the implementation of HF for ICMDs in Saskatoon.

The interviews with stakeholders focused on the characteristics and needs of the ICMD population in Saskatoon as well as the feasibility of implementing HF in Saskatoon. More specifically, the interviews examined the factors that need to be considered or steps that would need to be taken to implement HF in Saskatoon, as well as anticipated barriers and challenges or existing strengths and opportunities in the Saskatoon context.

### 8.4.1 ICMDs in Saskatoon

The size of the ICMD population in Saskatoon is difficult to estimate. The Saskatoon Housing Coalition, however, estimates that 80% of their 120 clients are ICMDs while 20% of those clients have extensive needs due to their mental health and substance abuse issues. Furthermore, as an indicator of the size of the ICMD population, according to a stakeholder from the Saskatoon Health Region, Saskatoon Health Region's Brief Detox is full every night and over capacity.

### 8.4.2 Sub-populations of ICMDs

ICMDs in Saskatoon fall into many categories. The unique challenges for the subcategories stakeholders elaborated on are provided below (Table 6).

Table 6: *Subpopulations of ICMDs*

| Subcategory | Unique challenge |
|---|---|
| **Youth** | May be in denial about their mental illness, substance use, and how their substance use exacerbates their mental disorders.<br><br>Those leaving the foster care system or who previously had a youth worker now have to interface with the adult system.<br><br>Lack of supports for young men. |
| **Individuals who are newly diagnosed due to drug onset** | |
| **Adults in their 30s** | |
| **Adults in their 40-50s** | |
| **Older adults 60+** | Buildings may not be accessible; not enough nursing homes or hospice care, may be placed in the community with supports. |
| **Aboriginal persons** | More likely to live in poverty and experience discrimination.<br><br>Represent a higher proportion of complex clients. |
| **Growing immigrant population** | Currently do not have many ICMDs, but number of ICMDs will increase as the population grows. |
| **Individuals who have a mental disorder, a cognitive disability, and addictions** | Extremely challenging population. |
| **Individuals leaving the provincial justice system** | |

### 8.4.3 Existing Housing Options in Saskatoon

Regardless of the size of the Saskatoon ICMD population, stakeholders indicated that ICMDs in Saskatoon are not having their housing needs met, or are only having their needs met in the short-term. In fact, ICMDs in Saskatoon are thought to face the most challenges in accessing housing. Table 7 shows the housing options that stakeholders identified where ICMDs may currently be housed in Saskatoon.

Table 7: *New Housing Options for ICMDs in Saskatoon*

| Type of Housing | Housing Providers | |
|---|---|---|
| **Inpatient** | Dubé Centre | |
| **Detox/Intox Housing** | Brief and Social Detox (Saskatoon Health Region)<br>The Lighthouse | |
| **Emergency Housing** | The Lighthouse<br>Salvation Army<br>YWCA | |
| **Supportive Housing** | The Lighthouse<br>CUMFI<br>Saskatoon Housing Coalition<br>Salvation Army<br>YWCA | Quint Male Youth Lodge<br>EGADZ, My Homes<br>The Bridge<br>Approved Homes |
| **Affordable Housing** | The Lighthouse<br>CUMFI<br>Stewart Property Holdings | Quint Housing<br>Cress Housing<br>Saskatoon Housing Coalition |

### 8.4.4 Challenges faced by ICMDs in Saskatoon

Individuals with concurrent mental disorders face a number of challenges in the Saskatoon context with respect to accessing housing and support services, such as:

**Poverty.** Many ICMDs may not be able to work and therefore live in poverty, or they may have lost their income supports if they did not abide by social services guidelines (in terms of annual reviews or overpayments). As such, they cannot afford the market and may live in poor quality housing.

**Choice in housing options.**Individuals with concurrent mental disorders may have limited choices about where they can live in the city as their housing options are constrained by the approved home system and the affordability of housing. Furthermore, the location of housing influences clients' access to services. In the current housing

context, ICMDs in Saskatoon are not in the position to make choices about their housing, but must accept what they can get. Landlords are more likely to choose the "easier" renter. Even supportive housing spaces tend to be given to the clients with the least complex needs first and the most complex needs last. Finally, fellow tenants or neighbours may not want ICMDs in their buildings or neighbourhoods. Clearly, there is a need for a congregate supportive housing unit for ICMDs in Saskatoon.

**The process of housing.** The housing process can be confusing, intimidating, and overwhelming for ICMDs. Difficulty understanding the English or legal language of tenant agreements can prove to be a barrier to housing for some ICMDs, as can focusing on the paperwork itself. Not having references or encountering waiting lists for services and housing is another issue ICMDs face.

**Difficulty accessing services.** It can be difficult for ICMDs to successfully initiate, navigate, and/or follow through with the referral process for support services. This could be for any number of reasons, such as: a lack of access to a telephone; couch surfing; lost/confused the appointment time; lack of transportation; or stigma associated with mental health. Further, ICMDs may have previously burned bridges with service providers, housing providers, and family.

**Maintaining housing.** Many ICMDs have been evicted from housing previously, particularly if they find it difficult to abide by the expectations of drug and alcohol free housing.

**Discrimination and exacerbating factors.** Along with housing issues, ICMDs in Saskatoon face a number of other challenges, such as experiencing active psychoses, addictions, transience, and frequent crises. Furthermore, many ICMDs have physical health issues, including chronic diseases and may require chronic disease management (this is especially true as the population ages). Individuals with concurrent mental disorders may also encounter discrimination based on the way they look, present themselves, behave, as well as their communication skills leading to negative or judgmental attitudes and a lack of empathy from housing and service providers. These challenges may also be exacerbated by additional elements of their identities, situations, and histories such as their ethnicity, living in poverty or criminal justice involvement. Psychiatrists or support service providers may also choose not to work with clients because they are perceived to be too challenging.

### 8.4.5 Considerations for Implementing Housing First for ICMDs in Saskatoon

The purpose of this section is to apply the HF implementation model to the Saskatoon context based on interviews with stakeholders, and staff and clients at CUMFI and Lighthouse. A discussion of what is currently in place and what is still needed to implement HF in Saskatoon with a specific focus on ICMDs will be presented. How to

obtain what is needed to successfully implement HF was previously discussed in the implementation model (see section 7.0) and elsewhere.

### *Phase 1: Gaining Support*

Saskatoon is currently in phase 1 of the implementation model. Obtaining community and even service/housing provider support for HF will be the greatest implementation challenge in Saskatoon. However, some steps are already in place to embark upon HF in Saskatoon and momentum is gaining and several activities are being implemented to gain support for a HF initiative in Saskatoon.

*Currently in Place*

**Steward.**One of the most important aspects of gaining support is identifying a steward who will take on a leadership role. It is necessary for an organization in Saskatoon to take on a leadership role and be accountable for implementing and maintaining HF**,** which includes gaining consensus and developing a shared vision for HF. This organization may be composed of sub-committees or other structures needed for implementation, fundraising, housing, support services and evaluation. For a successful governance and organization, Aboriginal services and perspectives will need to be integrated. Currently, there is a commitment to, and energy and support for, implementing HF via the United Way of Saskatoon. The United Way has taken on a leadership role in the Plan to End Homelessness and Housing First Taskforce. For instance, United Way has planned a charrette, established relationships in the community and are building community awareness. United Way was also perceived by the stakeholders interviewed to have credibility and pertinent stakeholders and partners have already been brought together (e.g., health, police, tribal council, individuals with lived experience). Additional work is already being done in Saskatoon that can be used to inform the implementation of HF or be incorporated into HF. For example, the COR and HUB groups, which bring representatives from a variety of sectors to the same table, may be in a position to take on HF after the term of United Way's commitment to lead HF concludes.

**Support.**Business and community members are supportive of HF and have the influence to pull people and resources together. One stakeholder noted that the Minister of Social Services is interested in moving forward with HF and HPS. Further, SHIP and the Community Advisory Board noted that they have moved toward funding HF projects. There are also a number of other parties interested or already moving forward with HF in Saskatoon, including a small number of landlords who are attuned to the issues of homelessness or who have had success with HF in other cities. Partnerships are being established and support from businesses and community leaders is increasing.

**Educating the community about Housing First.**The community's awareness of homelessness as a community problem should be considered.Some work has already

been done to create and build community awareness that homelessness is a *community*problem.For instance, the United Way charrette,, a Safe Streets study (focused on the homeless individuals in Saskatoon who use the most emergency services), and HF 101 sessions have brought attention to HF and have aimed to educate the community and gain support for HF. Saskatoon has also been drawing on experts to educate the community about HF.  However, additional efforts may be required to reduce stigma related to mental illness and addictions. One strategy to increase awareness may be to humanize the issue with personal stories. Another component to consider is commitment as a community to HF. In order to facilitate a community commitment necessary for HF, continued education efforts may be needed for the general public, private landlords, service providers (both those directly and indirectly involved in HF) and tenants in buildings involved in HF.

*Still Needed*

On the other hand, a great deal is still needed in order to obtain support.

**Clear vision and definition of Housing First.** A clear vision and definition of HF in Saskatoon has yet to be established. For instance, it is unknown whether there is a shared understanding of HF and its core principles or an agreement on priority populations of who will be housed first in Saskatoon.

**Support.** More support is needed in order to obtain sufficient levels of funding and in order to build a congregate supportive building for ICMDs. Additional support is needed from businesses and landlords. Since the HF philosophy is new to Saskatoon, community attitudes about HF and ICMDs may be difficult to change. Therefore attaining service and housing provider buy-in to the HF philosophy is vital. In Saskatoon, there is discrimination from landlords towards ICMDs and Aboriginal tenants. There is also some resistance to changing the status quo (e.g., resistance from Social Services to modify their services to fit HF). Agencies are used to their practices and may be reluctant to change their ways, for fear of losing their funding. Agencies may also be unwilling to give up their budget lines to make HF happen or sustain HF. There is a reluctance to redirect money from emergency services (where savings are expected) to sustain HF. Furthermore, there are also barriers presented by racism, classism, and stigma related to mental health and addictions throughout the Saskatoon community. In addition, recruiting landlords may be a challenge. It will be necessary to prove HF is a safe model for many to get on board. There are also concerns that HF may not work for all clients. As such, a back-up plan will be needed for clients who are not successful in HF (e.g., clients with extreme behavioural and addictions issues). Stakeholders also felt that it may not be efficient for clients who require only minimal supports to find/retain housing (e.g., clients who lost their housing because their rent increased or apartment complex was sold). Educating the community and those directly involved in HF can help ease concerns and gain support.

**Taking Action.**One key message stemming from the stakeholder interviews was to take action! Discussions about planning how to implement HF must be translated into action, as a tendency to focus on planning rather than on taking action was noted by several interviewees. For instance, identifying a steward and giving them the budget and mandate to start HF is a current challenge in Saskatoon. Ensuring that all relevant stakeholders are at the table at the outset, including Aboriginal stakeholders, is another challenge. Getting enough stakeholders and agencies on board to develop a proposal that outlines a common, shared vision to solicit funding from the provincial government could also present difficulties.

### *Phase 2: Obtaining Resources*

One of the strengths for HF in Saskatoon is the city's size. The city is large enough to have all of the necessary services, but small enough to effectively address homelessness.There are currently some resources in place that would aid the implementation of HF in Saskatoon.

*Currently in Place*

**Housing.**Housing projects that provide scattered site options are being funded. The City of Saskatoon itself builds 500 housing units a year, including 70 for harder-to-house individuals. In addition, the City of Saskatoon provides grants to develop housing, assists with re-zoning, and is considering alternative options for housing such as garden suites and garages. Despite these efforts, the housing options available are still currently limited. It would also be possible for existing congregate site models to be tailored for HF (e.g., the Lighthouse). Finally, some landlords have expressed interest or have been involved in HF in other cities.

**Support services.** Saskatoon has a number of support services that could be incorporated into an HF initiative. For instance, CUMFI provides transportation for most programs and mentorship (with a focus on FAS clients) and wrap-around supports (e.g., furniture). Further, CUMFI has demonstrated its ability to make connections with necessary service providers when there is a need (e.g., a designated justice worker) and assist clients with accessing services available in the community. With respect to furniture, the Village Green and the Salvation Army also have started initiatives to set-up stores where low-income persons can acquire furniture. Further, the Saskatchewan Rental Housing Supplement from Social Services already exists to provide rental support to clients. As such, ICMDs likely have access to it, but need help making the connections

There are also organizations already in place that have experience that could be used to inform the establishment of ICM or ACT teams in Saskatoon. Saskatoon Crisis Intervention has experience with being a 24/7 outreach team, the Health Bus is experienced with taking services directly to clients, and some organizations have

experience with scattered site housing, including providing supports and working with ICMDs. Furthermore, the Saskatoon Health Region already has experience with ICM (with a focus on HIV case management). In addition, there are physicians who are interested in working in teams in order to address the social determinants of health.

*Still Needed*

However, several resources are still needed.

**Funding and investments.**The most important resource needed is funding. A long-term investment in, and commitment to HF is integral to the success of the program. Funding will be required for rent (e.g., rental supplements, missed rent, damage deposit), as well as repairs, furniture, and utility set-up costs. In particular, sufficient funding is needed to cover housing costs, rental supplements and staffing costs. Rental supplements need to be available to ICMDs prior to being housed and should cover actual housing costs.Case management services and affordable housing also require funding. Many stakeholders believed that investment for the HF program should come from the Provincial government. More specifically, they perceived that the Ministry of Social Services should be targeted for funding related to rent and repair costs, while the Ministries ofHealth, Justice, Social Services, or a combination thereof should be targeted to fund case management (e.g., savings from reduced emergency services can be re-directed to sustain HF). In order to receive funding from the provincial government, however, it is necessary, to demonstrate that, as a community, Saskatoon is committed to HF (which requires a shared vision). Further, to garner support, pilot projects should be conducted to prove that success is possible and to attract additional investments and buy-in (it should be noted that business leaders are looking for business to invest). Fundraising can also be used to establish money for rent, repairs, and service costs. Finally, for a successful evaluation component, outcomes need to be established at the beginning and mechanisms (e.g., databases, homeless counts) to facilitate evaluation should be considered in this initial planning state.

**Housing.**Individuals with concurrent mental disorders need to have choices for various types of housing that encompass a variety of needs. For instance, accessibility, pets, exposure to sunlight, variety of neighbourhoods, congregate and scattered site, proximity to family and friends, proximity to supports and resources and access to transportation. There is also a need for more affordable housing units, long-term housing, supportive housing, and scattered site housing.

Individuals with concurrent mental disorders also need to have access to housing that has no restrictions or conditions around sobriety. There is, nonetheless, a role for housing that does require abstinence from drugs and alcohol. In addition, a rapid rehousing program is needed, and clients should not be blacklisted from all housing if they are evicted. Developing partnerships with landlords is needed as it is an integral component of

HF. This may require someone to inform landlords of the benefits of HF, as well as the establishment of a landlord committee with willing/interested landlords, including private, social, and supportive housing landlords.

A Housing Coordinator and staff dedicated to helping clients find housing would be useful. The coordinator and staff would support organizations across the city who do not have the time or expertise to help clients find housing or work with clients who are not able to find housing on their own. They could also develop a rental-housing list that lists landlords, open spaces, and HF spaces. Having a housing coordinator allows service providers to focus on service provision.

Long-term, not short-term services and housing is required. Scattered-site housing may not be appropriate for ICMDs as it can be isolating when clients are placed in neighbourhoods away from their social support and resource networks. Thus, congregate housing options must also be available. Scattered-site housing may be more appropriate for individuals that do not have a close attachment or association with a community or group of peers.

Within congregate housing, individuals should be housed in small, individual units. Communal living may be challenging, as it can exacerbate addictions or contribute to relational problems. As such, 24 hour staffing and programming on site is recommended. Landlords also must find ways to ensure continued support to clients while abiding by the *Landlord Tenancy Act.* In addition, housing should include furnished/unfurnished options and more supports for young men and those that fall through the cracks (e.g., homeless 17 year olds). There should also be consideration of factors in the local context (e.g., Aboriginal population) and more wrap-around supports.

The number of ICMDs with complex behaviours in a given program should be considered as too many can be too much for staff and residents. Residences should also be located in areas where supports and resources are easily accessible. Finally, a harm reduction approach is best suited to this population as clients may find it difficult to abide by expectations that they remain sober.

Housing availability and affordability are pressing concerns in Saskatoon. Currently, there are long waiting lists to get into supportive housing. CUMFI does not use waiting lists because they give clients a sense of false hope (CUMFI, 2013). Affordability also means having access to affordable housing with social service rates.

In Saskatoon there is a need for more:

- Permanent, long-term supportive housing
- Supportive housing for ICMDs that takes into account the needs of different age groups
- Small, individual units

- Affordable housing
- A greater variety of housing options within neighbourhoods
- Funds from the province to build more housing
- Funding programs that were available but no longer exist

More affordable/supportive housing (including housing without any restrictions about alcohol and drug use) may be required to ensure that all ICMDs can be housed and maintain their housing.

**Support services.** A case management/case coordinator group should be established that would serve the community of Saskatoon and that could be accessed through many organizations. This group or team should include mental health nurses, psychiatrists, psychologists, social workers, mental health workers, addictions workers, justice workers, and so forth. One support worker should be dedicated to the client. ICM and ACT teams are also required, as well as outreach teams that can be available 24/7 and able to go to the client. Assessment tools that will determine acuity and level of supports required should also be employed.

Consideration will also have to be given to finding and retaining qualified staff who can meet the needs of ICMDs. Training and clinical guidance support for staff will also need to be provided. Programming considerations for working with clients should also be taken into account:

- Services provided should take a person-centred approach and follow the principles of harm reduction
- Clients may need dedicated, coordinated supports
    - E.g., mentoring programs
- Clients may require advocacy for income security
- Life skills and vocational programming services may be needed

In addition, cultural awareness and sensitivity will be required when working with First Nation individuals. This includes considering culturally sensitive programming, ease of access into programs, strategies for overcoming language barriers, cultural awareness of food preferences, ceremonies, cultural values, and so forth.There also is a need to extend services beyond the core, which requires a better public transportation system.

### *Phase 3: Implementing the Program*

*Currently In Place*

**Service delivery.**Saskatoon has some experiences that may aid in the implementation of HF. For example, psychiatrists already do on-site visits at CUMFI, so making ‘house calls’ will not be an issue for some professionals. Some organizations have

experience with scattered site housing including providing supports and working with ICMDs (e.g., CUMFI; Saskatoon Housing Coalition). Also, many service providers already know each other and have established relationships.

**Program monitoring and evaluation.**Some stakeholders expressed concerns about the government requesting more detailed monitoring of community progress and outcomes rather than progress from individual programs. Agencies were concerned that they may lose their direct connection to, or voice with, the government. Privacy restrictions and regulations may also limit information sharing about clients. However, due to HUB and COR, government is working on new regulations around privacy and sharing information, which may improve these issues in the future.

*Still Needed*

There are also some significant changes that need to occur to implement HF in Saskatoon.

**Integrated Housing First system.**Although Saskatoon has many resources, a system needs to integrate all these resources so they work together to provide housing and support services to ICMDs in an efficient manner. As such, a coordinated planning function is needed to outline the process for housing individuals and provide them with support services. As well, one collaborative entry point (i.e., no wrong door approach) should be utilized. A collaborative and integrated approach is needed to provide coordination between housing and support service providers so each service can focus on its own area of expertise, but work together.

**Acceptance.**Housing providers will also have to learn to accept all clients, even those that prove challenging. Accepting ICMDs may be difficult particularly because most residences currently have barriers for entry such as abstinence. Educating housing providers about HF may help improve acceptance and change attitudes.

***Phase 4: Sustaining Housing First in Saskatoon***

At this time, there are no Saskatoon specific strategies in place to sustain HF since it has yet to be implemented; however, continued community buy-in and moving the program towards self-sufficiency are important. An evaluation component that includes monitoring the progress and outcomes as a community (e.g., through point-in-time homeless counts and a common database tracking client and program outcomes) will contribute to the sustainability of HF.

### 8.4.6 Community Consultation

At a community consultation process, stakeholders from the broader community were asked to reflect upon the above findings about implementing HF in Saskatoon. In so doing, some specific concerns were raise vis-à-vis implementing the HF model in the Saskatoon

context. For instance, members mentioned that if clients were to have immediate access to market housing, apartments would need to be readily available, but were concerned that landlords would be expected to absorb that cost. In a HF system, however, the HF program would cover the cost of turnover (if one client vacates an apartment they would have another available to move in immediately). Also mentioned was the importance of holding landlords accountable. There are very few options available to clients due to the low vacancy rates, and those that can be found are in a state of disrepair. Members stated that landlords are paid rent but disregard the state of their rental, which clients accept as they are afraid that a complaint may result in their becoming homeless. Thus, the possibility of having a set of standards by which landlords would agree to abide was raised.

Community members also raised concerns about clients who use in drug and alcohol-free residences in Saskatoon and subsequently lose their home to attend detox. Members debated how a spot could be kept in a residence for a client and who would pay for that spot. There was a similar concern regarding available housing options for clients who leave the justice system. If they cannot access housing, it becomes necessary for them to return to the same negative environment and influences. These concerns highlight the resources that would need to be available for some individuals to be successful in a HF program.

Finally, community members noted when considering the application of a decentralized system to the Saskatoon context that there would be a tension between the mandates, goals and values of each organization and their alignment with the goals and values of HF in order to operate within that system. Therefore, in implementing HF in Saskatoon, work will be need to be done regarding how organizations can work together and still maintain their independence in a HF system. Other cities, such as Edmonton, have been able to successfully negotiate these types of issues and, as such, they are not insurmountable.

## 9.0 Discussion and Overall Conclusions

To conclude, the feasibility of implementing and scaling HF for ICMDs will be discussed followed by a general discussion and implementation recommendations. Finally, the general conclusion, limitations and future directions for HF and HF research for ICMDs will be offered.

### 9.1 Feasibility of Implementing and Scaling Housing First for ICMDs

The feasibility of adopting HF refers to the degree to which a HF initiative can be easily implemented. The feasibility of implementing a HF, therefore, depends largely upon the extent to which a given community is able to align the systems-level factors and requisite housing and support service factors needed to establish and deliver HF, as discussed previously. Rather than re-iterating the various factors that may influence implementation

and, consequently, feasibility, we will highlight some of the key findings that came from the Saskatoon evaluations that may influence the feasibility of implementing HF in a smaller city such as Saskatoon.

One of the major challenges of implementing HF in a city like Saskatoon will be Phase 1 of the proposed implementation model. Community involvement in the HF process and education to reduce discrimination and change attitudes will be a major obstacle to overcome in order to successfully implement HF in Saskatoon and possibly similar cities that are new to HF. This is important because the existing political, economic, social, and/or cultural structures and values present in a community will influence whether it is possible, and how to successfully implement HF.

Assuming a community such as Saskatoon can shore up the necessary support for HF, the availability of and access to affordable housing, vacancy rates, housing markets, cooperation from landlords, regional legislation, funding, availability of a sufficient array of support services, and cultural values will be some of the greatest factors determining feasibility (Greenwood et al., 2013; Keller et al., 2013) and some of the greatest challenges for Saskatoon. For instance, access to affordable rental units in a tight housing market can be a substantial barrier to scattered-site housing. Moreover, limited housing availability will also consequently limit client choice of accommodation with respect to the quality, type, and location of housing units in which they may be placed. Due to the resulting consumer demand that may occur in conditions of limited housing, a decreased willingness among landlords, social housing providers, and housing authorities to rent accommodation to individuals with histories of incarceration, mental health problems, substance misuse, and/or homelessness may also occur as landlords can have their choice of tenants (Greenwood et al., 2013).

A main concern of implementing HF in smaller cities, particularly for ICMDs, is the availability of services. Smaller cities may lack the array of services available in larger centres (which may make it difficult to connect clients to all supports they require (Scott, 213b), but this did not appear to be an issue in Saskatoon. Smaller cities, by virtue of being small, may also have the potential for more cohesive networks, as there will be fewer partners among which it is necessary to coordinate activities (Scott, 213b), which appears to be consistent with Saskatoon.

In particular, access to 24-hour support is vital for ICMDs. Services that may be difficult to access, and consequently hinder the ability to support clients, include psychiatric services, community mental health services, substance abuse treatment, employment and educational services, nursing/medical care, social integration services, and 24-hour coverage (Greenwood et al., 2013; Nelson et al., 2012, 2013). In fact, in some communities, the success of ICM teams has been associated with having an adequate

service array as the role of ICM teams is to help clients access and connect to relevant, existing services, which is not possible when the necessary services do not exist, as is more likely the case in smaller centres (Nelson et al., 2013, 2014). It should also be noted that the availability of many of these services (e.g., psychiatric services, community mental health, substance abuse treatment) will directly impact the feasibility of HF for ICMDs.

Further, the extent to which HF partners are able to arrive at an agreement about how to realign existing services, including implementing a coordinated entry (i.e., intake/assessment process), and actively change their practices, will influence how easy it will be operate a HF program (Scott, 2013b). This may be a challenge for Saskatoon because a significant change in philosophy and possibly a realignment of existing services would be required to implement HF.

The feasibility of adopting HF will also be determined by the extent to which communities are able to adapt HF to meet their local realities. For instance, some sites may wish to shape the HF model to accommodate the needs of certain ethnic groups. However, their ability to do so will be dependent upon the extent to which they are able to hire and train culturally competent staff (Nelson et al., 2012). Again, the likelihood of having a pool of trained professionals to draw from is likely to be greater in larger centres.

Moreover, it is important to maintain fidelity to core HF principles when adapting HF to local contexts to avoid program drift (Nelson et al., 2014). Common examples of program drift in HF include moving away from providing clients with choices in terms of their housing and support services, and failing to separate housing from support services. Drift from core HF principles may impact the ability of an initiative to achieve its intended objectives and the known outcomes of HF (Nelson et al., 2014). As a result, whenever a community is establishing a new HF program, particularly if they are scaling the program to function with their local context, time should be taken to specify how the program and the components of the HF model will be implemented (Nelson et al., 2014). Moreover, any newly implemented HF initiatives should be evaluated for their fidelity to core HF principles (Nelson et al., 2014). Stefancic, Tsemberis, Messeri, Drake, and Goering (2013) developed a fidelity assessment to assist communities with such tasks. Durlak and DuPre (2008) suggest that it is unrealistic to expect the perfect or near perfect implementation of programs in replication sites, but that positive results can be obtained with replication sites that demonstrate levels of fidelity from 60-80%. This suggests that some level of program adaption is inevitable and Durlak and DuPre (2008) found some evidence that adaptations may even contribute to better implementation and, consequently, program outcomes in some situations, assuming that programs continued to adhere to theoretically important components of the model. Thus, they recommend that “the prime focus should be on finding the right mix of fidelity and adaptation” (Durlak&DuPre, 2008, p. 341).

In summary, the feasibility of HF will be dependent upon on the number of facilitators relative to the number of barriers that may either lend themselves to, or hinder the implementation of a HF initiative (Seffrin, Panzo& Roth, 2009; Torrey et al., 2012). Further, the size of the community may influence the likelihood that some of the facilitators of, and barriers to, HF will be present. Although many issues relevant to HF are directly tied to the size of the community, the implementation of HF should consider how HF can or should be implemented given the constellation of elements known to impact implementation that are present in a given community,. For instance, small centres and larger centres alike may have limited access to affordable housing, funding, service providers, and so forth.

## 9.2 General Discussion and Implementation Recommendations

In general, the feasibility of implementing HF initiatives for ICMDs is dependent on a number of factors including community support and funding, existing resources and the opportunity to establish new resources needed to implement HF. A general discussion of implementing HF initiatives will be presented with corresponding implementation recommendations.

**Support.**In any given community, the existing political, economic, social, and cultural structures and values present will influence whether it is possible to successfully implement HF and how an initiative will be implemented.First, and foremost, HF will only be feasible if sufficient levels of support and acceptance of the principles and philosophy guiding HF can be found to pursue an initiative among service providers, policymakers, and the general public (Greenwood et al., 2013).

Gaining support and community buy-in may also help increase funding for HF through fundraising and government grants which is required to ensure the sustainability and success of these programs, particularly for the much needed congregate supportive housing residence for ICMDs. Having strong leadership and a steward for the initiative is an effective way to gain community support for HF, as is research, engaging the community and media strategies.

**Funding.**Sufficient funding to cover housing costs, rental supplements, and staffing costs will also determine whether it is possible to launch a HF initiative. In particular, without some form of initial investment, a HF initiative may not be able to establish a strong enough platform upon which it can launch itself or may not be able to provide the intended range of supports to clients (Greenwood et al., 2013). In particular, initial investments and funding from a variety of sources and community and stakeholder involvement and education is recommended to sustain the program in the long-term. Gaining support and community buy-in of HF can help obtain funding.

**Accessing Housing First.**When a community adopts HF, an organizational structure should be in place to manage the program and the program should adopt a decentralized system to ease the process of entry. Housing should be provided to those with the highest acuity (or those that are in greatest need) first. Working with existing structures is the most effective way to ease implementation.

**Availability of affordable and appropriate scattered site housing options for ICMDs.**Communities need to develop their own local plan, with strategies that will work to engage and attract landlords to be involved in the project (Keller et al., 2013). In addition, limits to housing stock may limit the program's ability to quickly rehouse participants who lose their housing. In such conditions, HF initiatives that are established may only be sustainable if governments also simultaneously implement new options, strategies, or funding mechanisms to overcome barriers related to housing stock. Housing options are required in order to house clients in the house of their choice.

**Collaboration among service providers.**Extensive partnerships between rental, housing and service providers are recommended to successfully implement HF. In communities where there is already collaboration among service providers, it may be easier to make the transition to HF (Nelson et al., 2012). Joint training, information sessions and other methods were discussed to increase collaboration among these groups.

**Access to congregate housing.**The literature and current research on HF support the contention that individuals with higher levels of needs may fair better in long-term supportive congregate housing (Nelson et al., 2013; Patterson et al, 2013). It is recommended that long-term congregate supportive housing units for ICMDs follow the guidelines outlined by the Corporation for Supportive Housing Dimensions of Quality and include: 24 hour support, medication management, specific floors dedicated to specific groups depending on the local context and need, trained and empathetic staff, and a wide range of optional programs and services (e.g., life skills programming to assist with recovery). Lessons learned from the building of other congregate sites provided several implementation suggestions and methods of reducing costs.

**Availability and accessibility of support services.**Availability and accessibility of support services pertaining to psychiatric, mental health, and substance abuse treatment including 24-hour support (e.g., ACT teams) have been found to be important for ICMDs. Further, the availability of support services and resources that can be accessed or realigned to support HF, including a sufficient range of services and access to trained staff, will, in part, determine the feasibility of implementing HF. Individualized case management is recommended.

## 9.3 Conclusion

Designing and establishing HF programs is a difficult process and it is extremely important to identify key preconditions, common barriers, and factors that improve the likelihood that a program will become successful over the long-term. The overall goal of this project was to provide an in-depth look at how supportive housing programs (in particular HF Initiatives) targeting ICMDs were implemented. Understanding how cities provide housing to homeless ICMDs is a complex issue involving many different agencies. The current research provided a broad overview of the HF context in Vancouver, Edmonton and Regina and detailed three specific supportive congregate housing units for ICMDs in these cities. The implementation model developed from this investigation is fairly broad, partly because the plan must be adapted to each city's unique situation.

Our research was identified how current housing programs can be adapted to a HF model, including programs in smaller cities such as Saskatoon. More specifically, the main questions addressed in this research were: What does it take to implement HF for ICMDs? How can HF be scaled to smaller cities?

Several important factors were needed to successfully implement HF for ICMDs. The four main phases for implementing HF for ICMDs are 1) Obtaining support, 2) Obtaining Resources, 3) Implementing the program and 4) Sustaining the program. For ICMDs in particular, phase 1 of the implementation model would be the most challenging due to factors such as stigma leading to community resistance to HF initiatives. The implementation model outlined elements that are needed to successfully implement HF for ICMDs.

The second question addressed how HF can be implemented in smaller cities. Size was found to be less of an issue than the specific characteristics present in the city that may present barriers or facilitators to the HF implementation process. In particular, HF initiatives should be adapted to the local context in order to be successful, regardless of size. Size may play a role in some of the factors that could influence implementation, such as the number of services and professionals available. The size of the city, however, is only one of the many factors that could influence the implementation of HF. In fact, smaller cities may have certain advantages for implementing the HF process. For example, housing service providers may already have existing relationships with other service agencies, or at least be aware that they exist.

This project was designed to offer direction in the implementation of HF in future communities and to ensure that limited resources will be used more efficiently and effectively. Consequently, we are hopeful that the findings and recommendations of this project will havea significant, long-term impact on homelessness in Canada.

## 9.4 Limitations

Although a range of methods and housing agencies were involved in the present study, there were also some limitations in the research. One of the main limitations of the study was the fact that only one of the cities under investigation had implemented a Housing First model at the time of the study and the process evaluations were mostly limited to congregate supportive housing residences targeted to ICMDs. However, in reality, housing programs in cities without a formal HF model in place will range in how much they follow HF philosophy. For example, although Vancouver does not currently have a HF model in place, the program is more closely aligned with HF than the housing programs in Regina. This information is informative as it indicates that Vancouver already has support for HF (phase 1 of the implementation model) whereas more action needs to take place in Regina to gain support for HF.

Furthermore, all of the residences identified in the process evaluations were newly developed (MM, CP and PCA) and therefore it may be too early to identify all of the useful strategies and ongoing barriers and challenges experienced at these residences.

The representation of ICMDs in the study may have been weak. For example, clients who volunteered for the study may be biased in some way (e.g., motivated by especially good or bad experiences). In addition, it is possible that the ICMDs interviewed are not representative of the homeless ICMD population. The concerns and needs of ICMDs in the justice system, for instance, were not addressed in interviews with clients, stakeholders or program staff. It is worth taking note of this lack of representation, as it could be indicative of a gap in providing HF or other programs and services to ICMD clients in the justice system. It is also important to note that the literature review used to inform the implementation model was largely based on HF in general or on HF for individuals with a serious mental illness. It is likely, however, that “Individuals with a serious mental illness” includes ICMDs.

Because many of the clients/residents involved in the study experienced homelessness for so long, a great deal of medical and psychiatric information was likely unavailable or unreported. We cannot guarantee that all of the clients interviewed are ICMDs; instead, we consulted with service providers, in some cases, who drew on their knowledge and experience with their clients to conduct interviews with the appropriate individuals. For the same reason, some client case files were incomplete or unavailable for some participants, especially those who are new to the programs. In addition, clients/residents participating in the interviews may not have been as high needs as those who did not participate due to being high on drugs, not on routine medications, or distrustful of the researchers at the time of the interviews.

Furthermore, program documents were not up to date and did not reflect current practices at some of the sites and the perspectives reflected in our study only represent a

subset of all possible stakeholders in Saskatoon. The project focused on ICMDs, however specific information about the size of the ICMD population in Saskatoon does not exist.

Although this study was conducted to suit the needs of the City of Saskatoon, only two of the available programs were thoroughly evaluated, limiting the potential to access a complete range of perspectives. However, this limitation was mitigated through engagement in a public consultation.

Despite these limitations, a wide range of housing programs were reviewed with a specific focus on the hard-to-house subpopulation of ICMDs producing several lessons learned and a HF implementation model. This information can inform the implementation of HF models in cities currently without such models and also help improve current HF programs.

### 9.5 Future Directions

Housing First initiatives are emerging across Canada and the world (Gulliver, 2014). Organizations responsible for the implementation of these initiatives should pay particular attention to ICMDs, as they constitute a large proportion of the homeless population and they stand to benefit greatly from HF programs (Patterson et al., 2013).

The current research investigated HF models with a specific focus on supportive housing residences for ICMDs. However, more research is needed on how HF can accommodate the ICMDs who continue in the cycle of homelessness. The ICMD sub-population itself may be quite diverse; therefore research assessing the effectiveness of HF for different acuities of ICMDs may also be warranted. Housing First programs would benefit from research targeting this acute group to determine how HF can address and serve their needs.

## 10.0 References

References


Acquired Brain Injury.(n.d.).*Outreach teams* [Brochure]*.* Retrieved from http://www.health.gov.sk.ca/abi-outreach

Alberta Safety Codes Council. (2008). *Barrier-free design guide*. Retrieved from https://sccuat web.sharepoint.com/Public/Documents/2008_SCC_BFDG_ FINAL_protected.pdf.

American Psychiatric Association.(2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Barker, S., Barron, N., McFarland, B., & Bigelow, D. (1994). A community ability scale for chronically mentally ill consumers: Part 1: Reliability and validity. *Community Mental Health Journal, 30*, 363-383.

Benjaminsen, L. (2013). *Housing First Europe: Local evaluation report Copenhagen*. Retrieved from http://www.homelesshub.ca/resource/copenhagen-housing-first

BC Housing.(n.d.-a). *How to connect with a homeless outreach worker*. Retrieved from http://www.bchousing.org/Options/Emergency_Housing/HOP

BC Housing.(n.d.-b). *Supportive housing registration service*. Retrieved from http://www.bchousing.org/Options/Supportive_Housing/SHR

Boydell, K. M., & Everett, B. (1992). What makes a house a home? An evaluation of a supported housing project for individuals with long-term psychiatric backgrounds. *Canadian Journal of Community Mental Health, 11*(1), 109-123.

Building Partnerships to Reduce Crime.(n.d.)*The HUB & COR model.* Retrieved from http://www.saskbprc.com/index.php/what-s-working/the-hub-and-cor-model

Canada Mortgage and Housing Corporation. (2013). Project profile: Pacific coast apartments. Retrieved from http://www.cmhc-schl.gc.ca/en/inpr/afhoce/afhoce/prpr/upload/Pacific-Coast-Apartments-EN.pdf

Canada Mortgage and Housing Corporation. (2002). *Evaluating housing stability for people with serious mental illness at risk for homelessness.* Ottawa: Author.

Canadian Alliance to End Homelessness (n.d.).*A plan, not a dream: How to end homelessness in 10 years*. Retrieved from http://www.caeh.ca/wp-content/uploads/2012/04/A-Plan-Not-a-Dream_Eng-FINAL-TR.pdf

Canadian Homelessness Research Network.(n.d.).*Homeward Trust Edmonton:*

*Housing First.*Retrieved from http://www.homelesshub.ca/ ResourceFiles/HomewardTrust.pdf.

Central Urban Métis Federation Inc. (n.d.). *Central Urban Metis Federation Inc.* Unpublished document, Saskatoon, SK: Author.

Central Urban Métis Federation Inc. (2008) *Spring/summer 2008 newsletter. Retrieved from http://www.cumfi.org/sites/default/files/newsletters/NewsletterMay2008.pdf*

Central Urban Métis Federation Inc. (2013). *CUMFI Wellness Centre: Mentoring services for persons with cognitive disabilities yearend report 2012-2013.* Unpublished document, Saskatoon, SK: Author.

City Spaces (2008b).*Nanaimo's response to homelessness action plan*. Retrieved from https://www.nanaimo.ca/assets/Departments/Community~Planning/Social~Planning /Nanaimos~Response~to~Homelessness~Action~Plan/080707_Nan_Strategy.pdf

Clark, C., & Rich, A.R. (2003).Outcomes of homeless adults with mental illness in a housing program and in case management only.*Psychiatric Services, 54*(1), 78-83. doi:10.1176/appi.ps.54.1.78

Coast Mental Health. (n.d.-a). About coast. Retrieved from http://www.coastmentalhealth.com/about-coast

Coast Mental Health. (n.d.-b). Finding help: Housing. Retrieved from http://www.coastmentalhealth.com/housing

Collins, S. E., Clifasefi, S. L., Dana, E. A., Andrasik, M. P., Stahl, N., Kirouac, M. Malone, D. K. (2012; 2011). Where harm reduction meets housing first: Exploring alcohol's role in a project-based housing first setting. International Journal of Drug Policy, 23(2), 111-119.

Corporation for Supportive Housing (2013).*CSH dimensions of quality supportive housing.* Retrieved from: http://www.csh.org/wp-content/uploads/2013/07/CSH_Dimensions_of_Quality_Supportive_Housing_guidebook.pdf

Drake, R.E. &Mueser, K.T. (2000). Psychosocial approaches to dual diagnosis. *Schizophrenia Bulletin, 26*(1), 105-118.

Durlak, J. A., &Dupre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology, 41*, 327-350.

Edmonton Committee to End Homelessness. (2009). *A place to call home: Edmonton's 10 year plan to end homelessness.* Retrieved from

http://www.homewardtrust.ca/images/resources/2011-08-17-15-36A-Place-to-Call-Home_Edmonton-10-Year-Plan.pdf

Edmonton Homeless Commission.(n.d). *About Us.* Retrieved from http://homelesscommission.org/index.php/aboutus

Gaetz, S. (2013a). A framework for Housing First. In S. Gaetz, F. Scott, & T. Gulliver (Eds.) *Housing First in Canada: Supporting communities to end homelessness: A framework for Housing First* (pp. 1-17). Toronto: Canadian Homelessness Research Network Press.

Gaetz, S. (2013b). Conclusion – Lessons learned. In S. Gaetz, F. Scott, & T. Gulliver (Eds.) *Housing First in Canada: Supporting communities to end homelessness: A framework for Housing First* (pp. 1-13). Toronto: Canadian Homelessness Research Network Press.

Gaetz, S., Donaldson, J., Richter, T., & Gulliver, T. (2013).*The state of homelessness in Canada 2013.* Toronto: Canadian Homelessness Research Network Press.

Gaetz, S., & Scott, F. (2013). Calgary, Alberta: Calgary Homeless Foundation. In S. Gaetz, F. Scott, & T. Gulliver (Eds.) *Housing First in Canada: Supporting communities to end homelessness* (pp. 1-22). Toronto: Canadian Homelessness Research Network Press.

Gaetz, S., Scott, F. & Gulliver, T. (Eds.). (2013). *Housing first in Canada: Supporting communities to end homelessness*. Retrieved from http://www.slideshare.net/TheHomelessHub/housing-first-in-canada-supporting-communities-to-end-homelessness

George Spady Society.(n.d.).*Clinical access team*. Retrieved from http://www.gspady.org/clinical-access-team/

Greenwood, R. M., Stafancic, A., Tsemberis, S., & Busch-Geertsma, V. (2013). Implementations of Housing First in Europe: Successes and challenges in maintaining model fidelity. *American Journal of Psychiatric Rehabilitation, 16*, 290-312.

Gulliver, T. (2014).Case studies.*The Homeless Hub*. Retrieved from http://www.homelesshub.ca/solutions/housing-first/case-studies

Hamilton, C. (2013, November 16). Lighthouse extends hours to meet higher demand*. The Star Phoenix.*Retrieved from http://www.lighthousesaskatoon.org/category/housing-plus/stabilization-emergency-shelter/

Homeward Trust.(n.d.-a). Canora Place.*Completed developments.* Retrieved from http://www.homewardtrust.ca/programs/completed-details.php?id=5

Homeward Trust.(n.d.-b). *Funders and supporters.* Retrieved from http://www.homewardtrust.ca/about/funders-supporters.php

Homeward Trust.(2012a). *Annual report*. Retrieved from http://www.homewardtrust.ca/images/resources/2013-06-21-12-40HT%20Annual%20Report%202012%20WEB.pdf

Homeward Trust.(2012b). *2012 Edmonton Homeless Count*. Edmonton, AB: Author.

Homeward Trust.(2011). *Housing first annual service plan.* Retrieved from http://www.homewardtrust.ca/images/resources/2011-08-17-15-42Housing-First-Annual-Service-Plan_2010-2011.pdf

Homeward Trust.(2010). Annual report. Retrieved from http://www.homewardtrust.ca/images/media/2011-08-16-14-422010_Annual_Report.pdf

Housing First Europe.(2013). *Final reports and contributions from the final Housing First Europe conference in Amsterdam, June 2013*. Retrieved from http://www.socialstyrelsen.dk/housingfirsteurope

Jasper Place Health and Wellness Centre.(n.d.-a). *News*. Retrieved from http://www.jphawc.ca/news.html

Jasper Place Health and Wellness Centre. (n.d.-b). *Whenworking@jphawc: Property management policy manual*. Edmonton, AB: author.

Johnsen, S. & Fitzpatrick, S. (2013). *Housing First Europe: Local evaluation report Glasgow.* Retrieved fromhttp://www.homelesshub.ca/resource/glasgow-housing-first

Keller, C., Goering, P., Hume, C., Macnaughton, E., O'Campo, P., Sarang, A., …Tsemberis, S. (2013). Initial implementation of Housing First in five Canadian cities: How do you make the shoe fit, when one size does not fit all? *American Journal of Psychiatric Rehabilitation, 16*, 275-289.

Kirsh, B., Gewurtz, R., Bakewell, R., Singer, B., Badsha, M., & Giles, N. (2009).*Critical characteristics of supportive housing: Findings from the literature, residents, and service providers.* Toronto, ON: Wellesley Institute.

Mental Health Commission of Canada. (2012). *Turning the key. Assessing housing and related supports for persons living with mental health problems and illnesses.* Retrieved from http://www.mentalhealthcommission.ca/English/node/562

Miller, W. R., &Tonigan, J. S. (1996).Assessing drinkers' motivation for change: The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). *Psychology of Addictive Behaviours, 10*, 81-89.

Morse, G. A., Calsyn, R. J., Klinkenberg, W. D., Helminiak, T., Wolff, N., Drake, R.,… McCudden, S. (2006).Treating homeless clients with severe mental illness and substance use disorders: Costs and outcomes. *Community Mental Health Journal, 42*(4), 377-404. doi:10.1007/s10597-006-9050-y

Mueser, K. T., Noordsy, D. L., Drake, R. E., & Fox, L. (2003). *Integrated treatment for dual disorders.* New York: Guilford Press.

Nelson, G., Stefancic, A., Rae, J., Townley, G., Tsemberis, S., Macnaughton, E.,… Goering, P. (2014). Early implementation evaluation of a multi-site Housing First intervention for homeless people with mental illness: A mixed methods approach. *Evaluation and Program Planning*, *43,* 16-26. doi: 10.1016/j.evalprogplan.2013.10.004

Nelson, G., Macnaughton, E., Caplan, R., Macleod, T., Townley, G., Piat, M.,… Goering, P. (2013). *Follow-up implementation and fidelity evaluation of the Mental Health Commission of Canada's At Home/Chez Soi project: Cross-site report.* Calgary, AB: Mental Health Commission of Canada.

Nelson, G., Rae, J., Townley, G., Goering, P., Macnaughton, E., Piat, M.,…Tsemberis, S. (2012). *Implementation and fidelity evaluation of the Mental Health Commission of Canada's At Home/Chez Soi project: Cross-site report.* Calgary, AB: Mental Health Commission of Canada.

Ornelas, J. (2013). *Housing First Europe: Local evaluation report Lisbon*. Retrieved from http://www.homelesshub.ca/resource/lisbon-housing-first

Patterson, M., Moniruzzaman, A., Palepu, A., Zabkiewics, D., Frankish, C.J., Krausz, M. & Somers, J.M. (2013). Housing First improves subjective quality of life among homeless adults with mental illness: 12-month findings from a randomized controlled trial in Vancouver, British Columbia*. Journal of Social Psychiatry, 48*, 1245-1259. doi:10.1007/s00127-013-0719-6

Pearson, C. L., Locke, G., Montgomery, A. E., &Buron, L. (2007).*The applicability of Housing First models to homeless persons with serious mental illness.* Washington: U.S. Department of Housing and Urban Development.

Phelan, M., Slade, M., Thornicroft, G., Dunn, G., Holloway, F., Wykes, T., et al. (1995). The Camberwell Assessment of Need: The validity and reliability of an instrument to assess the needs of people with severe mental illness. *The British Journal of Psychiatry, 167*, 589-595.

Phoenix Residential Society (2013).*2012-2013 Thirty-sixth annual report*. Regina, SK: Author.

Ranch Ehrlo Society.(n.d.).*About us*. Retrieved from http://www.ehrlo.com/about-us/

Regional Steering Committee on Homelessness – Regional Homelessness Plan Advisory Group. (2013). *Regional homelessness plan discussion paper: Housing First.* Retrieved from http://stophomelessness.ca/wp-content/uploads/2013/09/131009_Metro_Van_Handout_Housing_First_FINAL.pdf

Rog, D. J., & Randolph, F. L. (2002). A multi-site evaluation of supported housing: lessons learned from cross-site collaboration. *New Directions for Evaluation, 94*, 61-72.

Saskatchewan Approved Private Homes. (n.d.).*Home.*Retrieved from http://saph.ca/

Saskatoon FASD Supported Housing Project & Central Urban Métis Federation Inc. (2007). *Implementation of the Saskatoon FASD supported housing plan: A service model to provide one-on-one support for persons with FASD*. Unpublished document, Saskatoon, SK.

Scott, F. (2013a). Edmonton, Alberta: Nikihk Housing First/Homeward Trust. In S. Gaetz, F. Scott, & T. Gulliver (Eds.) *Housing First in Canada: Supporting communities to end homelessness: A framework for Housing First* (pp. 1-15). Toronto: Canadian Homelessness Research Network Press.

Scott, F. (2013b). Fredericton, New Brunswick: Community action group on homelessness. In S. Gaetz, F. Scott, & T. Gulliver (Eds.) *Housing First in Canada: Supporting communities to end homelessness: A framework for Housing First* (pp. 1-8). Toronto: Canadian Homelessness Research Network Press.

Scott, F. (2013c). Vancouver, British Columbia: The Vivian In S. Gaetz, F. Scott, & T. Gulliver (Eds.) *Housing First in Canada: Supporting communities to end homelessness: A framework for Housing First* (pp. 1-17). Toronto: Canadian Homelessness Research Network Press.

Scott, F. (2013d). Victoria, British Columbia: Streets to homes. In S. Gaetz, F. Scott, & T. Gulliver (Eds.) *Housing First in Canada: Supporting communities to end homelessness: A framework for Housing First* (pp. 1-11). Toronto: Canadian Homelessness Research Network Press.

Scott, F., &Gaetz, S. (2013). Lethbridge, Alberta: City of Lethbridge and social housing in action. In S. Gaetz, F. Scott, & T. Gulliver (Eds.) *Housing First in Canada: Supporting communities to end homelessness: A framework for Housing First* (pp. 1-14). Toronto: Canadian Homelessness Research Network Press.

SCYAP.(2012). *Home*. Retrieved from http://www.scyapinc.org/

Seffrin, B., Panzo, P. C., & Roth, D. (2009). What gets noticed: How barrier and facilitator perceptions related to the adoption and implementation of innovative mental health practices. *Community Mental Health Journal, 45*, 260-269.

Stefancic, A., Tsemberis, S., Messeri, P., Drake, R., & Goering, P. (2013). The Pathways Housing First Fidelity Scale for individuals with psychiatric disabilities. *American Journal of Psychiatric Rehabilitation, 16*, 240-261.

Torrey, W. C., Bond, G. R., McHugo, G. J., & Swain, K. (2012). Evidence-based practice implementation in community mental health settings: The relative importance of key domains of implementation activity. *Administration and Policy in Mental Health, 39*, 353-364.

The Alberta Secretariat For Action on Homelessness. (2008). *A plan for Alberta: Ending homelessness in 10 years*. Retrieved from http://human services.alberta.ca/documents/PlanForAB_Secretariat_final.pdf

Topor, D.R., Grosso, D., Burt, J., & Falcon, T. (2013). Skills for recovery: A recovery-oriented dual diagnosis group for veterans with serious mental illness and substance abuse. *Social Work With Groups, 36*(3), 222-235. doi:10.1080.01609513.2012.762489

Tsemberis, S. & Eisenberg, R.F. (2000). Pathways to housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities. *Psychiatric Services, 51,* 487-493. doi:10.1176/appi.ps.51.4.487

Wong, Y. I., Hadley, T. R., Culhane, D. P., Poulin, S. R., Davis, M. R., Cirksey, B. A.,…Wong, Y.-L.I. (2006).*Predicting staying in or leaving permanent supportive housing that serves homeless people with serious mental illness*. Philadelphia. PA: U.S. Department of Housing and Urban Development, Office of Policy Development and Research.

Yanos, P. T., Barrow, S. M., &Tsemberis, S. (2004). Community integration in the early phase of housing among homeless persons diagnosed with severe mental illness: Successes and challenges. *Community Mental Health Journal, 40*(2), 133-150.

# 11.0Appendices

## 11.1 Index/Glossary of Terms

**ABI –** Acquired Brain Injury

**ACT team-**Assertive Community Treatment team**–** Provides higher intensity supports to clients. Comprised generally of a multidisciplinary team of professionals (e.g., psychiatrists, doctors, social workers, nurses, substance abuse specialists, peer support workers, case managers, and/or employment and education specialists).

**Acuity-** Used to determine the appropriate supports (level, frequency, intensity) for a client. A client's acuity is measured by taking into account the number of individual and systematic issues faced by a client and the severity of those issues. These issues could be medical, mental health, addictions, experiences of violence, age, life skills, education, employability, and social supports.

**AISH –** Assured Income for the Severely Handicapped– Alberta assured income

**Approved home –** Approved Private Service Homes – Private homes that provide a family atmosphere as an alternative to institutional living for individuals with cognitive, mental health and sometimes physical disabilities (Saskatchewan Approved Private Homes, n.d.)

**Barrier-free –** Having few obstacles for individuals with physical, mental or sensory disabilities.

**CAT-** George Spady Clinical Access Team – An intensive HF outreach team that provides individualized support services to chronically homeless individuals and families (George Spady Society, n.d.)

**Congregate Housing-** Housing in which many HF clients live in a single building

**CP - Canora Place-** Self-sustaining, supportive housing development in Edmonton

**CUMFI –** Central Urban Métis Federation Inc. - Métis owned and operated community-based, non-profit and charitable organization in Saskatoon

**CWC-** CUMFI Wellness Centre

**ETO -** Efforts to Outcomes **–** Case management and data collection system used by Homeward Trust in Edmonton

**Financial trusteeship-** Having a government agency, an organization or an individual act on the behalf of the client to help manage and/or budget his/her money.

**FAS –** Foetal Alcohol Syndrome

**FASD**- Foetal Alcohol Spectrum Disorder

**GRAI –** Graduated Rental Assistance Initiative **–** HT rental assistance initiative for Edmonton clients who have graduated from the HF program and are independent except for the ability to cover the market rent.

**HUB and COR –** Model comprised of two components geared towards community mobilization. HUB provides immediate, coordinated and integrated responses to address situations individuals or families with elevated risk factors face. The COR component focuses more broadly on community safety and wellness looking towards long-term community goals and initiatives (Building Partnerships to Reduce Crime, n.d.).

**HT** – **Homeward Trust** – A non-profit organization established in 2008 that acts as the funder and the management body responsible for the implementation of Edmonton's 10-year plan.

**HF – Housing First** – A current service model within the mental health system for homeless Individuals with concurrent mental health disorders. Using this model, clients are provided with permanent housing regardless of their mental health conditions, substance abuse, or agreement to participate in treatment (Gaetz, Scott, & Gulliver, 2013; Tsemberis& Eisenberg, 2000).

**ICMD-** Individual with Concurrent Mental Disorders

**ICM Team-** Intensive Case Management team**-** Typically helps clients with lower needs, and may require intensive support for a shorter, time-limited period. Focus on case management to broker services for clients.

**Intake worker-** Member of a HF team who assists a client with intake into the HF program (e.g., completing SPDAT assessments; helping the client get housing).

**JPHAWC – Jasper Place Health and Wellness Centre –** A health and wellness centre in Edmonton that is responsible for the creation of the Canora Place HF development.

**LihFT-** Low Intensity Housing First Team geared towards rapid rehousing.

**Medication management –**Medication is provided to clients in pre-determined amounts as prescribed.

**MHCC-** Mental Health Commission of Canada

**NIMBY-** Not In My Backyard- Community resistance to HF developments in their own neighbourhoods

**Permanent Housing -**Clients can live in building for life, more in line with HF philosophy (Kirsh et al., 2009).

**PCA –**Pacific Coast Apartments

**PTSD-** Post Traumatic Stress Disorder

**Rental Assistance Program –** Clients can receive partial funding towards their rent while in Edmonton's HF program.

**RPC – Regional Psychiatric Centre –** Psychiatric centre in Saskatoon.

**SAID -** Saskatchewan Assured Income for Disability

**SAP -** Saskatchewan Assistance Program **–**Income assistance program

**Saskatoon Crisis Intervention –** A 24/7 outreach team in Saskatoon

**Scattered Site-** When independent HF units are located throughout a city.

**SCYAP –** Saskatoon Community Youth Arts Programming – Offers visual and graphic training to Saskatoon's youth at risk in a safe, supportive space (SCYAP, 2012)

**SHIP –** Saskatoon Housing Initiatives Partnership

**SHRS-** Saskatchewan Rental Housing Supplement

**SOS referral –** Recent homeless individuals who have children or are vulnerable in some way can be accepted in the HF program through an SOS referral

**SPDAT- Service Prioritization Decision Assistance Tool –** Developed by OrgCode and designed to prioritize which clients should receive a HF intervention next and to assist in developing supports and case planning for that client.

**Supportive Housing –** Housing that provides clients with supports on an ongoing basis, as without these supports they will be at risk again for losing their housing (Kirsh et al., 2009).

**Terwillegar –** Proposed JPHAWC housing project development in the Terwillegar community in Edmonton

**The Lighthouse-** Lighthouse Supportive Living Incorporation - a community based non-profit organization located in downtown Saskatoon

**Transitional Housing-** Interim housing that is not intended to be permanent

**YWCA-** Young Women's Christian Association

## 11.2 Case File Data Extraction Sheet

**Case File Review/Outcome Evaluation: Data Extraction Sheet**

**Participant Number:_____ Circle: PCA / Triage**

**If information is not available please respond with N/A*

**Client Program Details**

1. Date of most recent entry into the residence (MO/DY/YR): _____

2. How was the client referred during their most recent stay at the residence?
   - ☐ Self-referred
   - ☐ Homeless Shelter (specify) _____
   - ☐Case/outreach worker (specify) _____
   - ☐ Friend/Family
   - ☐Other (specify) _____
   - ☐ Information not available

3. Number of times client has entered the residence including the most recent time: _____
   (If 1, skip to question 6)

4. What was the date of the client's most recent discharge from the residence? (if currently discharged, use previous discharge date)

   (MO/DY/YR): _____

5. Where was the client discharged to during their last stay at the residence?
   - ☐ Streets
   - ☐ Homeless Shelter (specify) _____
   - ☐ Supportive Housing (specify) _____
   - ☐ Friend/Family
   - ☐ Long-term independent housing (specify) _____
   - ☐Other (specify) _____
   - ☐ Information not available

6. Length of time in program as of July 31,2013 (days): _____

7. Length of time in program since their current admission (days): _____

8. Where did the client live prior to entry into the program?
   - ☐ Streets
   - ☐ Homeless Shelter (specify) _____
   - ☐ Supportive Housing (specify) _____
   - ☐ Friend/Family
   - ☐ Long-term independent housing (specify) _____
   - ☐Other (specify) _____
   - ☐ Information not available

9. Is the client's current residence (PCA or Triage) more stable than their previous residence?
   - ☐Yes (explain) _____
   - ☐No
   - ☐Information not available

10. How long has the client been without stable housing (e.g., on the streets, shelters, etc.) prior to entry into the program (months): _____

11. Which of the following are reasons why the client is unable to maintain housing? (check all that apply):
   - ☐ Mental Health issues (specify) _____
   - ☐ Financial Issues
   - ☐ Substance abuse issues
   - ☐ Choice
   - ☐ Behaviour (specify) _____
   - ☐ Can't find appropriate housing (reason) _____
   - ☐ Other (specify) _____
   - ☐ Information not available

12. What was the reason for the client's most recent eviction?
   - ☐Mental Health issues (specify) _____
   - ☐Financial Issues (e.g., non-payment of rent)
   - ☐Substance abuse issues (specify) _____
   - ☐Behavioural issues (specify) _____
   - ☐Other (specify) _____
   - ☐Information not available

**Client Demographic Information**

13. Age as of July 31, 2013 (years): _____

14. Sex:
   - ☐ Male
   - ☐ Female
   - ☐ Other
   - ☐ Information not available

15. Ethnicity:
   - ☐ Caucasian
   - ☐ Aboriginal (First Nation, Inuit, or Metis)
   - ☐ African Canadian
   - ☐ Asian
   - ☐ Other, please specify:_____
   - ☐ Information not available

16. Marital status:
    - ☐ Single/never married
    - ☐ Married
    - ☐ Separated
    - ☐ Divorced
    - ☐ Widowed
    - ☐Currently in a relationship
    - ☐ Information not available

**Education, Employment and Income**

17. Client's highest level of education completed:
    - ☐Grade 8 or lower
    - ☐Grade 9 to 11
    - ☐ High school diploma or equivalent
    - ☐Some post-secondary education (i.e., college or university courses)
    - ☐College or university certificate or diploma
    - ☐University degree (i.e., Bachelor's degree or higher)
    - ☐ Information not available

18. Income assistance
    - ☐Yes (specify) _____
    - ☐No , If not, why? _____
    - ☐Information not available

19. Is the client employed?
    - ☐ Yes
    - ☐ No
    - ☐ Information not available

**Mental and Physical Health**

20. Does the client have a **substance abuse or dependence** disorder?
    - ☐ Yes, substance abuse or dependence disorder is diagnosed
    - ☐ Yes, substance abuse or dependence disorder is self-reported by client
    - ☐ Yes, substance abuse or dependence disorder is suspected by staff
    - ☐ No, no known substance abuse or dependence disorder (*skip to Question 23*)

21. When was the last date of the client's (admitted or suspected) substance use?
    (MO/DY/YR):_____

22. What substances does the client typically use?
    (1) _____
    (2) _____
    (3) _____
    (4) _____
    (5) _____

23. Does the client have an **alcohol abuse or dependence** disorder?
    - ☐ Yes, alcohol abuse or dependence disorder is diagnosed
    - ☐ Yes, alcohol abuse or dependence disorder is self-reported by client
    - ☐ Yes, alcohol abuse or dependence disorder is suspected by staff
    - ☐ No, no known alcohol abuse or dependence disorder (*skip to Question 25*)

24. When was the last date of the client's (admitted or suspected) alcohol use? (MO/DY/YR):_____

25. Please list all of the client's mental disorders according to whether they are diagnosed, self-reported by client, or suspected by staff.

***Please Note*:** *Mental disorders may include any Axis 1 or Axis 2 mental disorder, FASD, post-traumatic stress disorder (PTSD), or acquired brain injury. For the purposes of this question, please exclude substance abuse or dependence, and alcohol abuse or dependence as they are asked about above.*

**a. Diagnosed** mental disorders: (1) _____

(2) _____

(3) _____

(4) _____

**b. Self-reported by client** mental disorders: (1)_____

(2) _____

(3) _____

(4) _____

**c. Suspected (by staff)** mental disorders: (1) _____

(2) _____

(3) _____

(4) _____

26. Please list all of the client's **physical health** conditions (conditions may be diagnosed, self-reported by client, or suspected by staff).

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

27. What medications is the client currently taking?

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

28. Have problems in the following areas been noted during the client's most recent stay at the residence?

| | Yes | No | N/A | # of incidents/problems | Explanation |
|---|---|---|---|---|---|
| | | | | | |
| Ability to maintain housing | | | | | |
| Health and safety behaviours | | | | | |
| Substance abuse | | | | | |
| Financial | | | | | |
| Social Skills | | | | | |

**Housing Information**

29. Is the client currently residing at the residence?
    - ☐ Yes (skip to Q. 35)
    - ☐No
    - ☐ Information not available

30. When was the client most recently released? (MO/DY/YR):_____

31. Where was the client released to after their most recent stay at the residence?
    - ☐ Streets
    - ☐ Homeless Shelter (specify) _____
    - ☐ Supportive Housing (specify) _____
    - ☐ Friend/Family
    - ☐ Long-term independent housing (specify) _____
    - ☐Other (specify) _____
    - ☐ Information not available

32. How stable was the residence the client was most recently released to in comparison to their previous residence (PCA or Triage)?
    - ☐A more stable housing unit (e.g., longer term, permanent housing)
    - ☐A housing unit of similar stability
    - ☐ A less stable housing unit (e.g. on the streets)
    - ☐ Information not available

33. Is the client still at the place they were most recently released to?
    - ☐ Yes
    - ☐ No (Reason: _____)
    - ☐ Information not available

34. How well is the client doing at the place they were most recently released to?
    - ☐ Very good
    - ☐ Good
    - ☐ Fair
    - ☐ Poor
    - ☐Very Poor
    - ☐ Information not available

35. Did the client make housing plans while residing at the residence?
    - ☐ Yes (Describe) _____
    - ☐ No (Reason) _____
    - ☐ Information not available

36. If yes, is the plan for housing more stable than their current residence?
    - ☐ Yes (Describe) _____
    - ☐ No (Describe) _____

37. Did the client make efforts to secure more stable housing while residing at the residence?

☐ Yes (explain) _____

☐ No (why not) _____

☐Information not available

38. Has the client made changes in their behavior that would help them obtain more secure housing?

☐ Yes (explain) _____

☐ No (why not) _____

☐Information not available

39. Did the client eat meals at the residence?

☐ Yes (explain) _____

☐ No (why not) _____

☐Information not available

### 11.3 Consent Forms for Clients, Staff and Stakeholders


# Consent Form for Interviews with Clients

**Project Title:**

An Examination of the Implementation of Housing First Initiatives for Individuals with Concurrent Mental Disorders (ICMDs): Outcomes and Community Perspectives.

**Researchers:**

**Principal Investigator:**
Dr. Steve Wormith
Department of Psychology
University of Saskatchewan
s.wormith@usask.ca
306-966-6818

**Co-Investigator:**
Dr. Karen Parhar
Kwantlen Polytechnic
University
karen.parhar@kwantlen.ca
778-926-5273

**Research Staff:**
Dr. Lisa Jewell
Research Officer
University of Saskatchewan
lisa.jewell@usask.ca
306 -966 -2707

**Purpose of the Research Study:**

We are doing a study on providing supportive housing to people who have more than one mental health condition. We want to know how organizations can provide housing and supports in the most helpful way possible. We want to learn from clients, staff who work at housing agencies, and other people who are involved with these programs. We want to know what works best. This study is taking place in four cities: Vancouver, Winnipeg, Regina, and Saskatoon.

We would like to interview you because you live in supportive housing and also have more than one mental health diagnosis. We will ask you questions about:

- Where you have lived before
- How you got into your current program
- How well you like this program compared to others
- Whether you think the program you are in is helpful
- The role your mental health diagnoses have played in getting and keeping housing

The interview will take about 20 – 30 minutes. If you agree, we would like to record your interview. This will help us make sure we wrote your information down right. The recording will be destroyed after we check to make sure we wrote everything down right. Please ask any questions at any time.

We would also like to review your case files and database information to learn more about individuals who use supportive housing or shelters.

We will review your case files and the database for information about:

- You (e.g., your age, date of birth, gender, ethnicity)

- How long you have been in the program
- Who referred you to the program
- What mental health diagnoses you have
- What medication you take
- What services you use
- Changes in your mental health and behavior

We will not access your case files after March 31, 2014.

**Funding:**

The study has been paid for by the Government of Canada by the Employment and Social Development Canada (ESDC) Department.

**Potential Risks:**

You may find some of the questions asked to be personal. You can skip any questions you want to. You might also become upset if you think of a bad memory. You can stop the interview at any time. Anything you share will be kept private and safe. If you feel upset during or at the end of the interview you can tell the researcher and they will arrange for you to talk to someone from the program who can help you.

The researchers will not tell anyone that you have participated in an interview or what you said about the program. However, if you decide on your own to tell someone, there is a chance that they may not like it and they may treat you differently. If this happens you should talk to a trusted staff member.

**Potential Benefits:**

You will help us understand the best way to provide supportive housing to people with more than one mental health diagnosis.

**Compensation:**

You will be provided with a $10.00 gift card. You will receive this gift card even if you decide not to participate.

**Confidentiality:**

You will not be named in any reports or presentations that are made. Any of the information you provide will be grouped with the information provided by other people in any reports or presentations. The results of the study will be shared in fact sheets, reports, presentations, and journal articles.

The information you share will be kept private. It will be stored on a locked computer or in a locked filing cabinet at the university. We will keep your data for six years. After that, it will be destroyed.

**Right to Withdraw:**

Your participation is voluntary. You can skip any questions at any time. You can stop participating in this study at any time. If you wish to stop, we will end the interview. You will still get your gift card. It will not affect your standing in your program. We will not use any of the information you provided and it will be destroyed. You may choose to stop participating up until the written report has been released. After this, it is possible that some of your information will have been used in the

report. Please let staff or the researchers know if you decide to stop participating at some point after your interview and your information will be destroyed and not used in the study.

**Follow up:**

To obtain results from the study, please contact Dr. Karen Parhar at karen.parhar@ kwantlen.ca or Dr. Lisa Jewell at lisa.jewell@usask.ca. The results will be available after March 2014.

**Questions or Concerns:**

This project has been approved on ethical grounds by the University of Saskatchewan Research Ethics Board (insert date). Any questions regarding your rights as a participant may be addressed through the Research Ethics Office (ethics.office@usask.ca or 306-966-2975). Out of town participants may call toll free 888-966-2975.

**Consent:**

**I give consent to participate in the interview**..……**Yes** **No** (circle one)

**I give consent for my interview to be audio-recorded**..…… **Yes** **No** (circle one)

**I give the researchers permission to access my case files and database information**……. **Yes** **No** (circle one)

Your signature below indicates that you have read and understand the description provided;

"I have had an opportunity to ask questions and my questions have been answered. I consent to participate in the research project (in the ways noted above). A copy of this consent form has been given to me for my records."

_____ _____ _____

Name of Participant Signature Date

"I read and explained this Consent Form to the participant before receiving the participant's consent, and the participant had knowledge of its contents and appeared to understand it."

_____ _____ _____

Researcher Signature Date

# Consent Form for Key Stakeholders and Staff

**Project Title:**

An Examination of the Implementation of Housing First Initiatives for Individuals with Concurrent Mental Disorders (ICMDs): Outcomes and Community Perspectives.

**Researchers:**

**Principal Investigator:**
Dr. Steve Wormith
Department of Psychology
University of Saskatchewan
s.wormith@usask.ca
306-966-6818

**Co-Investigator:**
Dr. Karen Parhar
Kwantlen Polytechnic University
karen.parhar@kwantlen.ca
778-926-5273

**Research Staff:**
Dr. Lisa Jewell
Research Officer
University of Saskatchewan
lisa.jewell@usask.ca
306 -966 -2707

**Purpose and Objectives of the Research:**

The goal of this project is to provide an in-depth look at how supportive housing programs for individuals with concurrent mental disorders (ICMDs) are implemented to determine where improvements can be made and provide information about replicating the model on smaller scales. The need for, and feasibility of, implementing supportive housing programs for ICMDs in cities without such programs, with a particular focus on smaller centers, also will be assessed.

Specifically, this project includes: 1) a process evaluation of existing supportive housing programs for ICMDs in Regina, Vancouver, and Winnipeg; 2) an outcome evaluation of a supportive housing program for ICMDs in Vancouver; and 3) a needs assessment in Saskatoon to determine if there is need for a supportive housing initiative for ICMDs. Ultimately, through this research, an implementation model will be developed that describes how supportive housing programs for ICMDs can be implemented in cities of various sizes.

**Procedures:**

Because of your knowledge about and/or work with ICMDs who reside in supportive housing, we would like to ask you some questions about your experiences. The interview may include questions about housing programs/residences in which you are involved (e.g., how clients are referred, how long your waitlist is, how clients are connected to other supports or services, how your program is evaluated), what practices you think have been effective when offering supportive housing and other supports to ICMDs, challenges housing programs/residence have encountered, and other resources that you think are still needed to better support ICMDs living in supportive housing and/or who are at risk of homelessness. The interview will take approximately 45-60 minutes.

With your consent, the interview will be recorded to ensure that the information you impart is accurately recorded. The recording will be destroyed once notes are checked for completeness and accuracy. During the interview, please feel free to ask any questions regarding the procedures and goals of the study or your role.

**Funding:**

This research study is being funded by Employment and Social Development Canada (ESDC) through the Homelessness Partnering Strategy (HPS).

**Potential Risks:**

There are no known or anticipated risks to you by participating in this research. Participation in this study is completely voluntary and participants have the right to withdraw at any time. Although sensitive information will be discussed, all information received will be kept completely confidential. You will not be identified by name in any reports or publications that result from this research. However, due to the small number of people being interviewed for this study, there is a chance you could be indirectly identified because of the unique information or perspective you provide.

**Potential Benefits:**

As a result of your participation, you will contribute to understanding the most effective way to implement supportive housing models for ICMDs and the need for such services.

**Confidentiality:**

No personal identifying information will be linked to you or any other research participant. All research information gained from this research project, including your recorded interview, will be held confidential by the Researchers. Data will be stored securely at either the Centre for Forensic Behavioural Sciences and Justice Studies or at Kwantlen Polytechnic University (depending on the city where the data was collected) in either a locked filing cabinet or on a password protected computer/file. Data will be stored for six years; at that time, it will be destroyed. Only overall results, rather than individual data, will be reported in the future uses of agency reports, journal articles or conference presentations.

**Right to Withdraw:**

Your participation is voluntary and you can answer only those questions that you are comfortable with. You may withdraw from the research project for any reason, at any time without explanation or penalty of any sort. Should you wish to withdraw, we will terminate the interview and discard all previously obtained information. Your right to withdraw data from the study will apply until results have been disseminated by way of a written report. After this date, it is possible that some form of research dissemination will have already occurred and it may not be possible to withdraw your data.

**Follow up:**

You may be contacted a second time after your initial interview if the researchers determine that additional information is required or if they need to clarify the information you have already provided. In this event, you will be asked at the time of the second contact to verbally confirm your willingness to continue your participation in the research.

To obtain results from the study, please contact Dr. Karen Parhar at karen.parhar@ kwantlen.ca or Dr. Lisa Jewell at lisa.jewell@usask.ca. The results will be available after March 2014.

**Questions or Concerns:**

This project has been approved on ethical grounds by the University of Saskatchewan Research Ethics Board on June 24, 2013. Any questions regarding your rights as a participant may be addressed through the Research Ethics Office (ethics.office@usask.ca or 306-966-2975). Out of town participants may call toll free (888) 966-2975.

**Consent:**

**I give consent for my interview to be audio-recorded**..…… **Yes** **No** (circle one)

Your signature below indicates that you have read and understand the description provided;

"I have had an opportunity to ask questions and my questions have been answered. I consent to participate in the research project. A copy of this consent form has been given to me for my records."

| _____ | _____ | _____ |
|---|---|---|
| Name of Participant | Signature | Date |
| _____ | _____ | _____ |
| Researcher | Signature | Date |

## 11.4 Interview Guides for Staff, Stakeholders and Clients

**The following interview guides represent a sample of the questions that were asked at each site.**

**Key Stakeholder Interview Guide – Edmonton**

Thank you for agreeing to participate in this interview. Your participation is an important part of the research we are conducting on supportive housing for individuals with concurrent mental disorders. This interview consists of several questions that will take approximately 45-60 minutes. This interview is confidential and you can stop the interview at any time. If you don't understand a question don't hesitate to ask for clarification. You may not know the answer to all the questions, so please don't feel the need to answer those questions.

1. Please tell me a little bit about your background and your knowledge of supportive housing programs/residences for ICMDs like Canora Place?

2. What is your involvement with Canora Place?
    a. Can you tell me a little bit about how you work with Canora Place?

3. How has working with Canora Place been for your organization?
    a. What things seem to work well?
    b. What challenges or barriers have you encountered?

4. [Questions may be relevant depending on nature of involvement with Canora Place]
    a. How does the referral process to Canora Place work?
        i. How well does the process seem to be working?
        ii. Is anyone being missed (or overlooked or left behind) by doing referrals this way?
        iii. How long is the waitlist?

    b. How are the services you provide coordinated with Canora Place?
        i. Who provides what services?
        ii. What funding arrangements have been put in place to facilitate service provision?
        iii. What other steps have been taken to coordinate service provision?
        iv. Do the available services seem to be meeting clients' needs?
        v. What (if any) gaps are there in service provision?

5. Were you or your organization involved in the development or start-up of Canora Place? Can you tell me about that?
    a. What was the process that was followed?
    b. Who were the partners?
    c. How was funding acquired?
    d. How was the physical location of the building determined?
    e. What challenges or hurdles were encountered?
    f. What things seemed to facilitate the development process?

g. What factors were taken into consideration to ensure the sustainability of Canora Place?
h. How much did the development cost?

6. Reflecting now on how Canora Place is currently implemented, do you think it is implemented effectively?
    a. Why or why not?
    b. What values, principles, or philosophies underlie its programming? Do these principles or philosophies contribute to (or hinder) its success?
    c. What kind of staff are required to make this type of program successful?
    d. What challenges have been encountered by Canora Place?

7. What are the costs of running Canora Place that you know of?

8. Do you think Canora Place is a sustainable model? Please explain.
    a. Does Canora Place currently face any issues which may threaten its sustainability?
    b. What steps have been taken to ensure its sustainability?

9. How do places like Canora Place help to reduce homelessness in the community?

10. If you were an advisor or consultant to another group interested in setting up a similar program, what advice or guidance would you give them? What lessons learned would you recommend?

11. Is there anything else you would like to add?

12. Do you have any questions about the interview or research study at this time?

13. Would you like us to send you a summary of the results (written up in fact sheets) and/or the final report?
    a. If yes, what would be the best way to send it to you (e.g., email, mail, etc.)?

The key organizations involved in this study will also be provided with fact sheets that you can inquire about after March 2014.

**Thank-you for your participation.**

## Staff Interview Guide - Edmonton

Thank-you for agreeing to participate in this interview. Your participation is an important part of the research we are conducting on supportive housing for individuals with concurrent mental disorders. This interview consists of several questions that will take approximately 45-60 minutes. This interview is confidential and you can discontinue the interview at any time. If you don't understand a question don't hesitate to ask for clarification. You may not know the answer to all the questions, so please don't feel the need to answer those questions.

1. Please tell me a little bit about your background and your experience with Canora Place?
    a. What is your role here?
    b. How long have you worked here?
    c. What are your hours?

2. Can you tell me a little bit about aboutCanora Place?
    a. What is the goal of Canora Place?
    b. Does Canora Place subscribe to a particular philosophy or set of values or principles that shapes the services it provides and how they are provided? Please explain.

3. Can you tell me more about your role?
    a. What does a typical day look like for you? What are your responsibilities?
    b. How many clients do you work with? What is your case load?

4. Can you tell me about the clients who live here. What are the needs of your clients? Who is the program designed for?
    a. What types of mental disorders do your clients typically have?
    b. How many males and females live here?
    c. What is the minimum age clients have to be to live here? Maximum age?
    d. What rules are clients expected to follow when they live here?

5. What kinds of supports and services are available to clients who live at Canora Place? [can explore: mental health, medical, and recreational services]
    a. Are these services provided onsite or are they coordinated with another agency?
    b. What programming is offered to clients directly at Canora Place?
        i. Any cultural programming?
    c. What supports and services seem to be the most effective in supporting clients?
        i. What supports and services are most well-received by clients?
    d. What supports and services have not been effective in supporting clients?
        i. What supports and services have not been well-received by clients?
    e. What concerns or complaints (if any) do clients have about living here?
        i. Why do clients get involved with using while living at the residence?
        ii. What are the consequences for using while at the residence?

6. How do clients come to live at Canora Place? How are they referred to the program?
    a. What referral procedures are the most effective? The least effective?
    b. Is there another way referrals could be done?
    c. Is anyone being missed (or overlooked or left behind) by doing referrals this way?

7. What does intake involve?
    a. What kinds of tools or assessments are used?
    b. Who is involved in the intake process?

8. How long is your waiting list?
    a. How is the waitlist managed?
    b. What are some the challenges or barriers related to someone getting a spot to live at Canora Place?

9. How many people have left Canora Place since it opened?
    a. How frequently does turnover open?
    b. How many people have left the residence voluntarily?
        i. Has anyone ever been evicted from the residence?
    c. Where do clients go after they leave Canora Place?
    d. What strategies are used to ensure clients have someplace to live after leaving Canora Place?

10. What are the costs of running Canora Place? [*Staff may not be able to answer this, Executive Director should be able to.*]
    a. What are the costs involved?
    b. How much does it cost to house a person here?
    c. How do these costs compare to treatment in traditional/hospital settings?
    d. What is the cost of rent? What does it include?

11. Does Canora Place take part in any evaluation or planning processes? Please explain.

12. Can you tell me about the staffing of Canora Place?
    a. What kinds of roles are there? How many people work here?
    b. How does the hiring process work? Is there a staffing philosophy that helps guide the staffing process? (e.g., looking for people who have a person-centred approach to care)
    c. What challenges have been encountered with staffing? (e.g., lower wages, staff turnover)
    d. Are opportunities provided for staff education? Please explain.
    e. What made you want to work here?

13. Overall, do you think Canora Place is implemented effectively?
    a. If so, how?
        i. What keeps clients here?
    b. What are some challenges and lessons learned that have been encountered?
    c. Is the program functioning as intended?
    d. What changes would you recommend to improve Canora Place?

14. Do you think Canora Place is a sustainable model?
    a. Does Canora Placecurrently face any issues which may threaten its sustainability
    b. What steps (if any) have been taken to ensure its sustainability?

15. How do places like Canora Place help to reduce homelessness in the community?
    a. Where would your residents be living if they didn't live here?

16. If you were an advisor or consultant to another group interested in setting up a similar program, what advice or guidance would you give them? What lessons learned would you recommend?

17. Is there anything else you would like to add?

18. Do you have any questions about the interview or research study at this time?

19. Would you like us to send you a summary of the results (written up in fact sheets) and/or the final report?
    a. If yes, what would be the best way to send it to you (e.g., email, mail, etc.)?

The key organizations involved in this study will also be provided with fact sheets that you can inquire about after March 2014.

**Thank-you for your participation.**

## Client Interview Guide– Canora Place

Thank-you for agreeing to participate in this interview. Your participation is an important part of the research we are conducting on supportive housing for individuals with concurrent mental disorders. This interview will be around 20-30 minutes. This interview is confidential, your name will not be linked to your answers, and you can stop the interview at any time. If you don't understand a question or don't want to answer a question, please let me know. It's ok if you don't know the answer to a question.

1. Tell me a little about yourself.
    a. May wish to talk about education or employment if they bring it up here.

2. Where did you live before you lived at Canora Place?
    a. What was it like?
    b. Where else did you live in the past?

3. Where did you like living the least? Why?

4. Where did you like living the most? Why?

5. How does Canora Place compare to some of the other places you have lived at?

6. What do you think about living at Canora Place?
    a. What do you like about it?
    b. What do you dislike about it?
    c. What do you think would make Canora Place a better place to live at?

7. How did you get into Canora Place? (Describe the referral source, etc.)

8. Can you tell me what a typical day here is like for you? How do you usually spend your day?
    a. What kinds of activities or groups do they have here?
        i. Do you participate in any of them?
    b. Are there any activities, groups, or programs you wish they had here?

9. I was hoping we could talk about your mental health conditions for a couple of minutes.
    a. What are your mental health conditions?
    b. Have you ever struggled with alcohol or drugs? Please explain.
        i. What kind of drugs?
    c. Have either your mental health conditions or your addictions ever made it hard for you get or keep housing? If so, how?

10. Do you think that places like Canora Place help people from becoming homeless?
    a. Why or why not?
    b. [Alternatively] How has Canora Place helped you keep your housing?

11. Just before we close the interview, I would like to learn a little bit more about you.
    a. What is your ethnicity (e.g., First Nation, Metis, White, etc.)?
    b. What gender do you identify with? (e.g., Male, female, transgender)
    c. How far did you get in school?
    d. Are you working right now?
        i. How much do you work? Where do you work at?

12. Is there anything else you would like to add?

13. Do you have any questions you would like to ask about the interview or research study at this time?

14. Would you like us to send you a summary of the results (written up in fact sheets) and/or the final report?
    a. If yes, what would be the best way to send it to you (e.g., email, mail, etc.)?

Your organization will also be provided with fact sheets that you can inquire about after March 2014. Please contact [insert name and contact information here] if this interview has caused you negative feelings and you need to talk to someone.

**Thank-you for your participation!**

**Staff and stakeholder interview guides in Saskatoon differed due to their focus on what is needed for Housing First to be implemented in Saskatoon**

## Stakeholder Interview Guide – CUMFI

Thank-you for agreeing to participate in this interview. Your participation is an important part of the research we are conducting on supportive housing for individuals with concurrent mental disorders. This interview consists of several questions that will take approximately 45-60 minutes. This interview is confidential and you can discontinue the interview at any time. If you don't understand a question don't hesitate to ask for clarification. You may not know the answer to all the questions, so please don't feel the need to answer those questions.

1. Please tell me a little bit about your background experience and knowledge of supportive housing for ICMDs.
    a. What is your role?
    b. How long have you worked in this area?

2. [If referred by CUMFI] What is your involvement with CUMFI?
    a. Can you tell me a little bit about how you work with CUMFI?
    b. How effective do you think CUMFI is in addressing the needs of ICMD clients?
        i. Are there other models of service delivery that you think would be more effective in addressing the needs of ICMD clients?

3. What other housing services are currently being provided to ICMDs in Saskatoon that you are aware of?
    a. Which of these services seem to be the most effective? The least effective? Please explain

4. From your perspective, what are the characteristics of ICMDs living in Saskatoon? (e.g., demographic characteristics – male/female; age; ethnic groups; families/singles; types of mental disorders; problem severity)

5. How many ICMDs do you think there are in Saskatoon?
    a. Of these, how many do you think have their housing needs met?
    b. In other words, how many do you think are homeless or are at risk of homelessness?

6. Do you think there is a need for additional supportive housing for ICMDs in Saskatoon? Please explain.
    a. What gaps currently exist in housing for ICMDs in Saskatoon?
    b. What do you think is the estimated demand for supportive housing for ICMDs in Saskatoon?

7. Are there particular barriers that ICMDs are likely to encounter when accessing housing in Saskatoon?

8. Are there particular barriers that ICMDs are likely to encounter in accessing or using the programs/services available for them?

9. *Part of our project is to determine whether it would be feasible to adopt a Housing First approach in Saskatoon to house ICMDs. We are defining Housing First an approach to ending homelessness that centers on quickly providing homeless people with housing and then providing additional services as needed. The basic underlying principle of Housing First is that there are no housing readiness requirements, individuals can choose the location and type of housing, individualized support services are available to clients, a harm reduction approach is taken where absolute sobriety is not required to maintain housing, and an emphasis is placed social and community reintegration.*

   Do you think it is feasible to implement a Housing First initiative for ICMDs in Saskatoon?
   a. What *strengths and opportunities* do you think currently exist in Saskatoon that would facilitate a Housing First approach for ICMDs?
   b. What *challenges or barriers* currently exist in Saskatoon that may hinder the implementation of a Housing First approach for ICMDs?
   c. What conditions would need to be put in place to make it possible to implement Housing First for ICMDs in Saskatoon?

      i. What *partnerships* do you think need to be in place? (e.g., federal, provincial, municipal government; landlords and property managers; addictions treatment; community-based organizations)

      ii. What *type of housing of facilities* would be most appropriate for ICMDs in Saskatoon? (e.g., congregate/apartment housing or scattered site?)
         1. Are these types of facilities currently available?
         2. [If apartment housing] Where do you think such a residence should be located?

      iii. What *resources* would be necessary? (e.g., housing availability, rental supplements, furniture supplies, funds to repair damages caused by tenants)

      iv. What *programming and services* would be necessary?
         1. Do these programs and services currently exist in Saskatoon?
         2. How would the current system of program delivery need to be modified to accommodate a Housing First for ICMDs approach?

      v. What *type of staff* would be required to support Housing First for ICMDs?
         1. De-centralized Intensive Case Management (ICM) or Assertive Case Management (ACT) teams?
         2. Support and programming provided in-house by trained staff?
         3. Staff dedicated to helping clients find housing and interacting with landlords?

      vi. What considerations would need to be taken into account to ensure the *sustainability* of a Housing First approach for ICMDs in Saskatoon?

d. What *qualities unique to the Saskatoon context* should be taken into account in developing such a model or residence?
    vii. May relate to city size, ethnic make-up of ICMD population, existing collaboration among potential partners, readiness/interest in Housing First, other populations that may be a priority, etc.

10. Is there anything else you would like to add?

11. Do you have any questions you would like to ask about the interview or research study at this time?

12. Would you like us to send you a summary of the results (written up in fact sheets) and/or the final report? If yes, what would be the best way to send it to you (e.g., email, mail, etc.)?

The key organizations in this study will also be provided with fact sheets that you can inquire about after March 2014.

**Thank-you for your participation!**

## Staff Interview Guide – CUMFI

Thank you for agreeing to participate in this interview. Your participation is an important part of the research we are conducting on supportive housing for individuals with concurrent mental disorders. This interview consists of several questions that will take approximately 45-60 minutes. This interview is confidential and you can discontinue the interview at any time. If you don't understand a question don't hesitate to ask for clarification. You may not know the answer to all the questions, so please don't feel the need to answer those questions.

### *Questions About CUFMI*

1. Please tell me a little bit about your background experience and knowledge of supportive housing for ICMDs
    a. What is your role here?
    b. How long have you worked in this area?

2. Can you tell me a little bit about CUFMI?
    a. What is the goal of CUFMI?
    b. Does CUFMI subscribe to a particular philosophy or set of values or principles that shapes the services it provides and how they are provided? Please explain.

3. Can you tell me about the clients who live here. Who is the program designed for?
    a. What are the needs of your clients?
    b. How many of your clients are ICMDs?
    c. What types of mental disorders do your clients typically have?
    d. How many males and females live here?
    e. What is the minimum age clients have to be to live here? Maximum age?
    f. What rules are clients expected to follow when they live here?

4. What kinds of supports and services are available to clients who live at CUFMI?
    a. Are these services provided onsite or are they coordinated with another agency?
    b. Do you have any services that are specifically designed for clients who are ICMDs?
    c. What supports and services seem to be most effective in supporting ICMD clients?
    d. What supports and services have not been effective in supporting your ICMD clients?
    e. Do you think your services are able to adequately address the needs of your ICMD clientele?
        i. Are there any additional supports or services you wish you could provide your ICMD clients to help further address their needs?
    f. What concerns or complaints (if any) do clients have about living here?

5. How do ICMD clients come to live at CUFMI? How are they referred to the program?
    a. What referral procedures are the most effective? The least effective?
    b. Is there another way referrals could be done?
    c. Is anyone being missed (or overlooked or left behind) by doing referrals this way?

6. How long is your waiting list?
    a. What types of clients primarily comprise your waiting list? (probe for ICMDs)
    b. What are some of the challenges or barriers related to someone getting a spot to live at CUFMI?

7. How many people have left CUFMI since it opened?
    a. How frequently does turnover happen?
    b. What are the reasons why clients typically leave? (e.g., eviction, voluntary leaves, graduated to another program)
    c. Are some types of clients more likely to leave than others? (probe for ICMDS)
    d. Where do clients go after they leave CUFMI?
    e. What strategies are used to ensure clients have some place to live after leaving CUFMI?

***Overall Questions about Saskatoon***

8. Besides your services, in Saskatoon, what other housing services are currently being provided to ICMDs that you are aware of?
    a. Which of these services seem to be the most effective? The least effective? Please explain

9. From your perspective, what are the characteristics of ICMDs living in Saskatoon? (e.g., demographic characteristics – male/female; age; ethnic groups; families/singles; types of mental disorders; problem severity)

10. How many ICMDs do you think there are in Saskatoon?
    a. Of these, how many do you think have their housing needs met?
    b. In other words, how many do you think are homeless or are at risk of homelessness?

11. Do you think there is a need for additional supportive housing for ICMDs in Saskatoon? Please explain.
    a. What gaps currently exist in housing for ICMDs in Saskatoon?
    b. What do you think is the estimated demand for supportive housing for ICMDs in Saskatoon?

12. Are there particular barriers that ICMDs are likely to encounter when accessing housing in Saskatoon?

13. Are there particular barriers that ICMDs are likely to encounter in accessing or using the programs/services available for them?

14. *Part of our project is to determine whether it would be feasible to adopt a Housing First approach in Saskatoon to house ICMDs. We are defining Housing First as an approach to ending homelessness that centers on quickly providing homeless people with housing and then providing additional services as needed. The basic underlying principle of Housing First is that there are no housing readiness requirements, individuals can choose the*

*location and type of housing, individualized support services are available to clients, a harm reduction approach is taken where absolute sobriety is not required to maintain housing, and an emphasis is placed social and community reintegration.*

Do you think it is feasible to implement a Housing First initiative for ICMDs in Saskatoon?

a. What *strengths or opportunities* do you think currently exist in housing for ICMDs in Saskatoon that would facilitate a Housing First approach for ICMDs?
b. What *challenges or barriers* currently exist in Saskatoon that may hinder the implementation of a Housing First approach for ICMDs?
c. What conditions would need to be put in place to make it possible to implement Housing First for ICMDs in Saskatoon?

    viii. What *partnerships* do you think need to be in place? (e.g., federal, provincial, municipal government; landlords and property managers; addictions treatment; community-based organizations)

    ix. What *type of housing of facilities* would be most appropriate for ICMDs in Saskatoon? (e.g., congregate/apartment housing or scattered site?)
        1. Are these types of facilities currently available?
        2. [If apartment housing] Where do you think such a residence should be located?

    x. What *resources* would be necessary? (e.g., housing availability, rental supplements, furniture supplies, funds to repair damages caused by tenants)

    xi. What *programming and services* would be necessary?
        1. Do these programs and services currently exist in Saskatoon?
        2. How would the current system of program delivery need to be modified to accommodate a Housing First for ICMDs approach?

    xii. What *type of staff* would be required to support Housing First for ICMDs?
        1. De-centralized Intensive Case Management (ICM) or Assertive Case Management (ACT) teams?
        2. Support and programming provided in-house by trained staff?
        3. Staff dedicated to helping clients find housing and interacting with landlords?

    xiii. What considerations would need to be taken into account to ensure the *sustainability* of a Housing First approach for ICMDs in Saskatoon?

d. What *qualities unique to the Saskatoon context* should be taken into account in developing such a model or residence?
    xiv. May relate to city size, ethnic make-up of ICMD population, existing collaboration among potential partners, readiness/interest in Housing First, other populations that may be a priority, etc.

15. Is there anything else you would like to add?

16. Do you have any questions you would like to ask about the interview or research study at this time?

17. Would you like us to send you a summary of the results (written up in fact sheets) and/or the final report? If yes, what would be the best way to send it to you (e.g., email, mail, etc.)?

The key organizations in this study will also be provided with fact sheets that you can inquire about after March 2014.

**Thank you for your participation!**

### 11.5 Recruitment Letters and Invitations for Staff, Stakeholders, and Clients


- Do you currently live in supportive housing?
- Have you experienced homelessness or had trouble finding a place to live in the past?
- Do you have more than one mental health problem?

If so, we would like to include you in our research!

The Centre for Forensic Behavioural Science and Justice Studies at the University of Saskatchewan, together with Kwantlen Polytechnic University in British Columbia, is currently doing a research study to learn about the experience of homelessness and living in supportive housing among individuals with more than one mental health problem.

We are currently looking for persons to participate in an interview and answer some questions that will help us find out if supportive housing helps people with more than one mental health problem. We will ask questions about how well you are doing in the program/residence and collect some basic background information about you.

Your information will be kept confidential and, if you choose to participate, your name will not be revealed to others or included in the data we are collect.

**If you are interested in participating, or would like more information, please contact [Insert Name] by phone at 306-xxx-xxxx or email at [insert email address]**

**Your help with this study is much appreciated!**

UNIVERSITY OF SASKATCHEWAN

**Centre for Forensic Behavioural Science & Justice Studies**

9 Campus Drive, Room 110B Arts
Saskatoon, SK, S7N 5A5
Telephone: (306) 966-2687
Facsimile: (306) 966-6007

Dear Phoenix Residential Society Staff Member,

The Centre for Forensic Behavioural Science and Justice Studies at the University of Saskatchewan (in collaboration with Kwantlen Polytechnic University in British Columbia) is currently conducting a study to examine the implementation of Housing First/supportive housing initiatives for individuals with concurrent mental disorders (ICMDs). This project is funded by Human Resources and Skills Development Canada through the Homelessness Partnering Strategy.

The objectives to the project are to: 1) identify what it takes to implement an effective Housing First/supportive housing program for ICMDs, including an examination of how these programs bring together experts and link with institutions to help prevent persons with concurrent disorders from becoming or remaining homeless, 2) identify how to adopt these programs in smaller centres that do not specifically service ICMDs to better meet the needs of this population, and 3) examine ongoing challenges and barriers to implementing such a program for ICMDs in small urban centres.

To achieve these objectives, the project involves a process evaluation of existing supportive housing programs in Vancouver (Pacific Coast Apartments), Winnipeg (agency to be determined) and Regina (Phoenix Residential Society), as well as an outcome evaluation in Vancouver and an assessment of need for supportive housing initiatives / Housing First model of housing for ICMDs in Saskatoon, based on an examination of the housing programs and client needs of two local organizations: Lighthouse Supported Living and Central Urban Métis Federation Inc.

At this time, we are seeking staff members of your organization to participate in an interview and answer questions about various aspects of the program including implementation, referral procedures, ability to meet ICMD client needs, and service coordination as well as the sustainability of the program. We hope to interview approximately three staff members. Interviews will take approximately 45-60 minutes.

If you are interested in participating in this project, please contact one of the following project team members:

[Insert name], Graduate Student Research Assistant
[Insert e-mail address]
306-XXX-XXXX

Lisa Jewell, Research Officer
lisa.jewell@usask.ca
306-966-2707

Please note that [Insert name] will be on site at McEwen Manor from July 15 to19 and will be available to interview staff members during that time. She can conduct interviews during the day or evening, depending on what is most convenient for staff. If you are not available that week, but wish to participate in an interview, we can arrange a meeting with you at a more convenient time.

Sincerely,
J. Stephen Wormith, Ph.D.
Principal Investigator

UNIVERSITY OF SASKATCHEWAN

**Centre for Forensic Behavioural Science & Justice Studies**

9 Campus Drive, Room 110B Arts
Saskatoon, SK, S7N 5A5
Telephone: (306) 966-2687
Facsimile: (306) 966-6007

Dear Community Stakeholder,

The Centre for Forensic Behavioural Science and Justice Studies at the University of Saskatchewan (in collaboration with Kwantlen Polytechnic University in British Columbia) is currently conducting a study to examine the implementation of Housing First/supportive housing initiatives for individuals with concurrent mental disorders (ICMDs). This project is funded by Human Resources and Skills Development Canada through the Homelessness Partnering Strategy.

The objectives of the project are to: 1) identify what it takes to implement an effective Housing First/supportive housing program for ICMDs, including an examination of how these programs bring together experts and link with institutions to help prevent persons with concurrent disorders from becoming or remaining homeless, 2) identify how to adopt these programs in smaller centres that do not specifically service ICMDs to better meet the needs of this population, and 3) examine ongoing challenges and barriers to implementing such a program for ICMDs in small urban centres.

To achieve these objectives, the project involves a process evaluation of existing supportive housing programs in Vancouver (Pacific Coast Apartments), Winnipeg (agency to be determined) and Regina (Phoenix Residential Society), as well as an outcome evaluation in Vancouver and an assessment of need for supportive housing initiatives / Housing First model of housing for ICMDs in Saskatoon, based on an examination of the housing programs and client needs of two local organizations: Lighthouse Supported Living and Central Urban Métis Federation Inc.

You have been identified by one of the participating organizations as someone with knowledge of the need for supportive housing for ICMDs in your community, and/or as a community partner or individual that either assists with or benefits from existing program delivery, whether directly or indirectly. As such, we would like to invite you to participate in an interview for the project that will help us to better understand needs, gaps, barriers and opportunities and best practices for housing initiatives targeted to ICMDs. The interview will take approximately 45-60 minutes.

If you are interested in participating in this project, please contact one of the following project team members:

[Insert name], Graduate Research Assistant
[Insert e-mail]
306-XXX-XXXX

Lisa Jewell, Research Officer
lisa.jewell@usask.ca
306-966-2707

Sincerely,

J. Stephen Wormith, Ph.D.
Principal Investigator

## 11.6 Guidelines for Recommending Clients and Client Eligibility Checklist


**Guidelines for Recruiting Clients to Participate in Interviews**

1. Clients must have the *ability* to provide **informed consent**. That is, clients must be able to understand:
    a. What the study is about;
    b. Their rights as participants in the study;
    c. The risks and benefits of participating.

2. Clients must have the *ability* to participate in a 20-30 minute face-to-face interview.
    a. Clients may choose not to participate, but we would like you to assess whether this is something that clients *can* do if they decide to participate.

3. Clients must be living at one of your agency's residences
    a. We would like to invite clients who are *currently* residing in your supportive housing and transitional housing units to participate in our study.
    b. Clients currently residing in emergency shelter housing *are not* eligible for the study.

4. Clients must be ***individuals with concurrent mental disorders*** (ICMDs) to participate in the study.
    a. To be considered an ICMD, clients must have a(n):
        i. alcohol abuse or dependence disorder + one (or more) mental disorders
        ii. substance abuse or dependence disorder + one (or more) mental disorders

    b. For the purposes of this study, a ***mental disorder*** may include:
        i. An Axis 1 disorder:
            - depression
            - anxiety disorders
            - bipolar disorder
            - attention deficit hyperactivity disorder (ADHD)
            - autism spectrum disorder
            - anorexia nervosa
            - bulimia nervosa
            - schizophrenia

        ii. An Axis 2 disorder
            - paranoid personality disorder
            - schizoid personality disorder
            - schizotypal personality disorder
            - borderline personality disorder
            - antisocial personality disorder
            - narcissistic personality disorder
            - histrionic personality disorder
            - avoidant personality disorder
            - dependent personality disorder
            - obsessive-compulsive personality disorder
            - intellectual disabilities

iii. An acquired brain injury

iv. Fetal alcohol spectrum disorder (FASD)

v. Post-traumatic stress disorder (PTSD)

c. Disorders may either be ***diagnosed* or *strongly suspected***. For the purposes of this study, acceptable methods for confirming the existence of concurrent mental disorders include:
   i. Documentation in case files/databases
   ii. Medical records
   iii. Self-report by clients
   iv. Observation by staff/case worker

UNIVERSITY OF SASKATCHEWAN

Client ID:_____

## Checklist for Recruiting Clients – McEwen Manor, Regina

1. **The client is able to provide *informed consent*. That is, the client is able to understand what the study is about, their rights as a participant, and the risks and benefits of participating in the study.**

   ☐ Yes
   ☐ No

2. **The client is able to participate in a 20-30 minute face-to-face interview.**

   ☐ Yes
   ☐ No

3. **The client currently lives in McEwen Manor.**

   ☐ Yes
   ☐ No

4. **The client has concurrent mental disorders. These disorders may either be diagnosed or strongly suspected.** *Please check both boxes if both alcohol and substance abuse or dependence apply.*

   ☐ Alcohol abuse or dependence disorder + one (or more) mental disorders
   ☐ Substance abuse or dependence disorder + one (or more) mental disorders

5. **The following sources have been used to confirm that the client has concurrent mental disorders.** *Please check all that apply.*

   ☐ Case file / database documentation
   ☐ Medical records
   ☐ Self-report by client
   ☐ Observation by staff
   ☐ Other (please specify):_____

## 11.7 Guidelines for Recommending Stakeholders

UNIVERSITY OF SASKATCHEWAN

**Guidelines for Recommending Stakeholders to the Study**

We are looking for key informants or stakeholders who are knowledgeable about supportive housing for individuals with concurrent mental disorders (ICMDs) to participate in 45-60 minute interviews. Through the interviews, we hope to learn more about: 1) the delivery of supportive housing to ICMDs; 2) referral procedures; 3) service coordination; 4) the sustainability of supportive housing for ICMDs; 5) best practices for implementing supportive housing for ICMDs. Therefore, we would like to speak with individuals who are knowledgeable about the above.

We hope to speak to stakeholders who work in diverse areas. This may include representatives from:

- Municipal government agencies involved in housing program delivery, policy, or legislation
- Provincial government agencies involved in housing program delivery, policy, or legislation
- Service providers for ICMDs struggling with homelessness
- Other housing providers for ICMDs struggling with homelessness
- Funders of housing programs
- Chaplaincy groups
- Landlords
- Housing developers
- Community groups or organizations striving to address housing/homelessness, especially those with a focus on ICMDs
- Business owners
- Research organizations
- Volunteer organizations

If you know of anyone who could be a possible key informant, and their information is *publically available*, please provide us with that person's name, position title, and organization. Please send your recommendations to Lisa Jewell by phone (306-966-2707) or email (lisa.jewell@usask.ca).

If your recommendation(s)' contact information is *not publically available*, please forward them our study information and ask them to contact us directly (we have a letter that we can provide you). We wish to respect everyone's privacy and do not want to impose our study on individuals by using their private phone numbers and email addresses to contact them without their permission.

**Thank you!**