COMPARISON OF FOUR HOUSING FIRST PROGRAMS

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

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Summary

This report presents the program and client characteristics of four programs which utilize a *"housing first"* approach or program model to provide housing and support services to persons with mental disorders and co-occurring addictions. It then compares client profiles and housing stability of participants with those of the Mental Health Commission of Canada's (MHCC) At Home/Chez Soi project.

The organizational auspices, design, structure, philosophy and client orientation of each program is explored before moving on to an analysis of client-level characteristics. As the MHCC's study did not report on the organizational context of its housing first programs it is not possible to compare the current programs with that study on dimensions of organizational context of services delivery.

The client profiles across all sites mirrored, with a few exceptions, those of the MHCC study. Clients had comparable lengths of homelessness, low educational achievement and reported multiple health issues. Findings from the study indicated that clients in all programs had serious mental health problems and that most also reported life-time addictions problems.

Client retention in housing, the primary aim of any housing first program, was comparable to or substantially better than that reported in the MHCC study. One site, Houselink, had exceptionally high housing stability outcomes over a five-year period. Given that client profiles indicate all persons housed had significant mental health and addictions issues, and that all programs used a *"housing first"* orientation, we examined the programmatic differences that may account for different outcomes. Some operational issues factors were not completely evaluated, but should be included in further analysis: level of specialized training in mental health, addictions and homeless serves by front-line staff, quality and frequency of clinical supervision and support, and the extent of the use of full integrated

teams in services provisions. Several factors appear to contribute to the finding of high retention rates in housing: program maturity, organizational sponsorship by a mature (long-standing) organization, the use of a recovery model, promotion of an intentional community, and the meaningful integration of persons with lived experience into program governance and operations.

A Comparison of Four Housing First Programs

The aims of this study were to examine if *"housing first"* programs established independently of a research project, and operating under different principles of service delivery would serve the same types of clients as those under a focused "housing first" study such as the At Home/Chez Soi study conducted by the Mental Health Commission of Canada. It examined client profiles among programs and finally concluded with comparison with the housing first programs that were established as part of the At Home/Chez Soi conducted by the Mental Health Commission of Canada (Goering et al., 2011). Individual case studies of each program are presented and then followed by a fulsome comparison of program designs and operations. The programs involved in this study, presented in alphabetical order, are: Homebase in Calgary, Houselink Community Homes (Houselink) in Toronto, Pathways to Housing in Calgary (the Alex Pathways), and Pathways to Housing, Edmonton (P2H-ED),

Background

Since deinstitutionalization, the belated and limited response by various government agencies (health, housing, incomes supports) to the needs of those living with a mental illness (MI) and substance use (SU) problems has resulted in huge gaps between need and availability (Government of Canada, 2009) (Waegemakers Schiff, Schneider, & Schiff, 2008). The ongoing move to community treatment resulted in many persons who had become dependent on the care of others thrust into the community without the financial and ancillary supports required for housing stability (Metraux, Byrne, & Culhane, 2010). While the near-total transformation of long-term psychiatric care from institutional settings to community- based care relieved state and provincial governments from the costly

burden of housing hundreds of thousands of persons impaired by a mental illness, few communities recognized, or planned, for appropriate housing necessary for persons whose ability to live independently was marginal. The literature on housing for those with mental illness and concurrent addictions has most often focused on clinical results such as reduction in symptoms, hospital care, less substance abuse and quality/satisfaction with life (Nelson, Sylvestre, Aubry, George, & Trainor, 2007). A number of studies have examined the incidence and prevalence of mental illness, primarily schizophrenia (Bijl & Ravelli, 2000; Schiff, Waegemakers Schiff, & Schneider, 2007) and the extent of disability resulting from mental illness and co-occurring addictions (Jans, Stoddard, & Kraus, 2004), (Mojtabai, 2011). Together, prevalence and disability create the need for appropriate housing with supports in the community (Ducharme, Knudsen, & Roman, 2006; Ridgway & Rapp, 1997; Waegemakers Schiff et al., 2008). Mental health consumers do not necessarily concur with the choices offered and the demands on them for compliance with housing rules (Srebnik, Livingston, Gordon, & King, 1995; Tsemberis, Gulcur, & Nakae, 2004). Resultantly, many leave housing, for a variety of reasons and become unstably housed (Sylvestre, Ollenberg, & Trainor, 2009). Thus the importance of stable, affordable, and adequate housing to prevent homelessness is well documented (Tutty et al., 2009).

Historically, mental health consumers have been regarded as a homogenous group in which all members require similar services and supports (Waegemakers Schiff, Schiff, & Schneider, 2010). At the same time, evidence shows that not all those who have had a mental illness stay in supportive housing, for some because it is too restrictive, others because it does not provide enough supports (Leff et al., 2009; Wong, Filoromo, & Tennille, 2007). Others issues include the extent to which these programs support a focus on recovery from serious mental illnesses and the degree to which consumers are incorporated as peer supporters in these programs (Davidson et al., 1999).

Some factors impact housing retention. The presence of an Assertive Community Treatment (ACT) team has been associated with community tenure for the seriously impaired (Nelson et al., 2007), and intensive case management (ICM) is a viable, less intensive and expensive option for others (Mares & Rosenheck, 2011). These comparisons

have not been made within a housing first program philosophy (Waegemakers Schiff & Rook, 2012). Thus we do not know what works for which sectors of the population. The importance rests in both providing an optimal level of support to prevent homelessness, and no more support than is necessary so that programs are cost-effective. It is also paramount that staff have the appropriate qualifications by way of training and experience since lack of either reduces program fidelity and effectiveness (Salyers & Tsemberis, 2007).

At the same time, the documentation on what works, and for whom, has most often neglected to detail the aspects of programs that assure success (Mowbray, Holter, Teague, & Bybee, 2003). Thus, program descriptions, in the literature, infrequently mention such critical issues as staffing patterns, (various professional and paraprofessional staff which represent various specializations: social work, psychology, nursing, rehabilitation studies, as examples), service intensity and frequency, as well as more subtle organizational dynamics as program philosophy and organizational culture (Bond, Drake, McHugo, Rapp, & Whitley, 2009; Waegemakers Schiff, 2001).

A recent and very relevant example is that of the "housing first" approach promoted by Pathways to Housing in New York. "Housing first" refers both to programs that have a common philosophy and to a specific program delivery model of housing for persons with co-occurring mental illnesses and addictions both of which provide housing without treatment or abstinence requirements. They follow a harm-reduction approach by prioritizing housing, assuring personal safety and domicile security without requiring sobriety of engagement in psychiatric treatment. They also adhere to a consumer preference model of location of housing in so far as is logistically and financially possible.

In over 12 publications, from 1999 to 2009, on one or more aspects of this initiative, none involved a program evaluation of either implementation or program processes, although excellent outcomes were presented. This left interested policy and program leaders with vague and indeterminate guidelines with which to develop this approach in other localities. It was not until 2010 that a manual of program specific details was published (Tsemberis,

2010). This present study strives to add to that documentation by providing program specific information on policies, procedures and operations that include but extend beyond client services specific guidelines. It also seeks to provide further understanding of how the housing first model can be effectively extended to chronically homeless persons who dare not identify as having a major mental illness.

Methodology

The focus of this evaluation was to provide documentation of all aspects of each program's organization and basic operating principles and procedures. This study employed a mixed methodology of qualitative and quantitative data.

The four programs that form part of this evaluation were selected for several reasons.
1. The Pathways programs in Calgary and Edmonton were the first "*housing first*" to be established in Canada according to guidelines developed by the Pathways to Housing in New York City. Both pre-date programs developed by the At Home Chez Soi study. 2. Both Pathways programs elected to collect client-level data using the same instruments that were used in the At Home/Chez Soi study sponsored by the Mental Health Commission of Canada MHCC). 3. Both Pathways programs have been in existence longer that the programs developed by the MHCC and have developed some program maturity and stability. 4. Homebase was established at about the same time that the MHCC programs were established and it also elected to use some of the same data collection tools to assess client status and progress. While its target population is not specifically those with a serious mental illness, it provided an opportunity to examine and analyze a program which uses a *housing first* approach but does not have the ACT team or an array of program based services (as is the case with the other programs. 4. Houselink was identified independently by the lead researcher as a *housing first* program with aspects unique to the Canadian context. It also has an impressive maturity as an organization providing *housing first* and employing a peer model of client/member engagement for over 37 years.

The program evaluation component included data from a number of sources: interviews with key program and organization staff and managers, meetings with clients, program documentation, manuals, annual reports and reports of previous studies of program components, as well as field notes from numerous program contacts. The program directors/heads of the agency of all programs were also interviewed. We also included the program guidelines used in Pathways Housing First programs (see Appendix 2) to determine the extent to which these programs followed this model.

A Caveat: The information for this study was collected over a period of nine months while there was also ongoing data collection and analysis of client-level information. During this time several program and system wide changes were introduced, which will affect referral and intake dynamics as well as program operations. While this study can serve as a baseline for existing protocols and procedures at the time information was collected. Further work would be appropriate to track the impact of these changes on program efficiency and effectiveness.

Program Descriptions

Homebase

Homebase is a housing program, operating on *housing first* principles, which is targeted at the rapid housing of chronically homeless individuals who fall outside of the scope of the pathways to Housing program. Pathways clients must have a diagnosis of a major mental illness, identified both by client history and by an intensive psychiatric exam by the staff psychiatrist prior to acceptance into the program. In contrast, by program mandate, Homebase clients may present with serious functional deficits but are not required to have a major mental illness. Those diagnosed with a major mental illness, are referred to the Alex Pathways program while those with a primary addictions dependency are generally referred to an addictions program. Thus serious undetected mental illnesses or addictions problems may be present in Homebase clients. These conditions will not result in discharge from the program but most frequently indicate the need for a referral to the Pathways program. According to program staff, co-occurring conditions will indicate a need for ultimate transition as Homebase, unlike Pathways which has no time limits on its services, is intended to act as a housing expedient and not a permanent support for those with disabling conditions.[1]

Organizational Auspices

Homebase is one of two *housing first* programs under the organizational auspices of the Alex Health Centre. The Alex is a multi-program health care agency whose mission is: "*delivering innovative and accessible health and social solutions"*. It has been in existence for over 40 years, has a tradition of providing health care services to inner-city impoverished areas, and focuses on providing primary medical care and housing support to

[1] In April 2012, the Calgary Homeless Foundation took possession of a building, which has a permit for a special care facility that can serve 21 tenants. The Alex's HomeBase program has a master lease contract to provide housing with support to tenants beginning in the spring of 2013.Subsequewntly the Alex Pathways program has taken on management of this building. This program, called Abbeydale, is not part of the present study.

some of Calgary's most vulnerable persons through addressing both health and social issues.

In 2006 it was asked by the Calgary Homeless Foundation to participate in the development of a *housing first* program for the city's most vulnerable and hard to house: persons with a mental illness and co-occurring substance abuse. This led to the development of Pathways to Housing as a comprehensive program that included housing and supports provided by an Assertive Community Treatment (ACT) team. In 2009 the Calgary Homeless Foundation asked the Alex to also develop a housing program for chronically homeless individuals who fell outside of the Pathways mandate. The extension into housing and supports to persons with mental illness and co-occurring addictions was a natural extension of the overall mission of the Alex to serve inner city persons who experience the effects of poverty and lack of adequate health care resources.

Homebase operates as a separate and distinct program within the Alex organization, utilizing its own dedicated staff for service delivery. Staffing and resources are not shared among programs and Homebase clients wishing to access other Alex Health Centre services must use the same application/entry procedures as other people in the community. Initially, Homebase and the Pathways to Housing programs occupied the office space in a shared site. A year ago Homebase relocated to its own space about one kilometer from the Pathways program. At this time, its base of operations is a distinct set of offices in a light industrial area of Calgary, just off the downtown core. While clients are seen at these offices, the preferred service delivery model is to see clients in their own homes and alternatively in other locations in the community that are of travelling convenience to clients.

Program eligibility

Homebase is mandated, by agreement with the Calgary Homeless Foundation, its chief funder, to house absolutely homeless individuals who have been without a residence for at least six months, and who do not meet the criteria of having a serious mental illness and co-occurring substance abuse problems. There are no barriers to housing those with a prior criminal history.

Intake and client admission challenges

Unlike the Pathways to Housing program, Homebase does not have a separate intake procedure that assesses for the presence of a mental disorder. Nor is there staff who are trained in assessments for these disorders, or in assessment for active addictions [2] Thus the program finds itself with clients who meet criteria for other programs but once admitted to Homebase, are kept as clients. Another result reported by program staff is that the program ends up housing people whose primary problems are severe dysfunctions due to personality disorders, and who then demonstrate considerable social and emotionally destructive behavior. Unlike Pathways, the Homebase staff do not have specialized training in how to work with persons with severe personality disorders. Because of these behavioral challenges, these clients are reported to absorb an undue amount of program resources.

Program Qualitative Descriptors

Homebase operates on an intensive case management (ICM) model of service provision with the following goals:

- Clients will remain stably housed

[2] AS this report was being finalized, Homebase had completed the process of hiring two staff with addictions training and experience. However, the information presented in this report reflects the lack of this staff.

- Clients will reduce justice, legal and health service usage (i.e. fewer emergency room visits and decreased number of police interactions)
- Clients will improve self-sufficiency (i.e. secure stable source of income and achieve personal goals)
- Clients will engage in mainstream services (i.e. improve social networks, access available social services such as food banks)

Referrals and case assignments

Individuals are referred by any of the local agencies which serve the homeless or can be self-referred. The referral process has changed in the last year. Until late 2013, Homebase conducted its own screening and intake, including maintaining a wait list. It has recently joined the centralized intake process for housing agencies in Calgary, which consists of the major housing providers under the Calgary Homeless Foundation funding umbrella. Following the generally screening and assignment by this centralized group, the program conducts an agency-specific intake and then the client is assigned to one of three[3] teams consisting of case managers, one of whom is then designated as the primary worker for that individual.

Services are offered five days a week (Monday – Friday) during normal business hours. Emergencies are referred to the local Distress Centre if they are of a mental health/addictions nature. No emergency services are offered. Services consist primarily of case management and referral. The program does not operate any dedicated activities beyond some addiction counseling (one person with training is on staff) and employment and money management training (by arrangement with another local NGO).

[3] Homebase has recently reorganized to two teams with a third team responsible for housing and landlord relations.

The program is organized into two teams of case managers, each with their own supervisor. Clients are assigned to case managers who each maintain a client load of approximately thirteen to seventeen 13 clients to each case manager. While the teams are organized for supervisory and management purposes, the case managers do not share clients. Case managers support each other in their work, but this is nominal as the direct service provision for clients falls to the case manager assigned to those individuals. There is no team sharing of work load or responsibilities.

The immediate goal of this program is rapid re-housing in accommodation that is within acceptable limits of space and location. A tight rental market and the scarcity of available housing makes this matching difficult to achieve. Each case manager is responsible for the determination of need, and linkage to support services for clients. Case managers are expected to meet with new clients twice a week and to then reduce the frequency of contact as clients are stable, without crises, in their housing. Frequency of contact and duration of contact are not linked and there is also no record that reports these individually, and thus these contacts may be as short as 15 minutes or last over an hour. Emergencies add to this contact load.

Housing

All Homebase clients are housed in apartments in various locations throughout the city. Leases are negotiated directly with clients, who are the lease holders. Staff assist in the process and act as a liaison with landlords. Rent deposits and rental supplements are made available through funding from the Calgary Homeless Foundation (provincial housing supplements). The program does not own any rental units and does not hold the lease on any units. Housing is scatter-site and case managers make every effort to avoid housing in buildings that already have a number of other clients.

Discharge criteria.

Although the program was organized to provide supports for one year after housing was obtained by a client, at the present time, there are no distinct criteria for "successful graduation" from the program. The program is moving towards the identification of graduation as a step to successful re-establishment of housing. The current, loosely defined criteria include stable housing at the same location for at least 12 months and no acute exacerbation of the need for other support services.

The lack of concrete discharge criteria also impacts the program in the instances where placement is unsuccessful and clients need to be relocated to another residence. Staff report that in some instances individuals have been re-housed six or more times. Landlord evictions are the most common reason and they often stem from illegal activity (drug dealing) on the part of tenants. Hoarding and poor sanitary behaviours which lead to unsanitary conditions and health code violations are another, but less prominent reason for housing loss. For example, although not a legal reasons for eviction, tenants who import bed bugs which then begin to infest an entire building, are more likely to be evicted for seemingly innocuous reasons. Some individuals default on rent payments and are evicted for rental arrears. Although the agency pay the rent supplement automatically, because there is no arrangement for automatic withdrawal of rent from personal bank accounts when monthly social support checks arrive, there is considerable uncertainty about the timely payment of rent. In the past, Home Base has stepped in to pay rents rather than have a client evicted. However, this process has been abused by some and has become an additional reason for the move to tighten discharge criteria.

Program level policies and procedures

Until recently, Homebase operated with a loose set of guiding principles on admission and continuation of client support. Procedural laxity extended to the frequency and regularity with which contact was expected of case managers with clients. There were guidelines but no clear policies on the length of time an apartment would be maintained if a client was institutionalized, either in hospital or jail. Nor was there a mechanism to readily transfer those more suitable for the Pathways program to that staff.

The Calgary Homeless Foundation, which funds both Pathways and Homebase, introduced a detailed case management guidelines document with the expectation that all funded programs would assure that staff are trained in case management protocols and procedures. While this is progressing, it is unclear as to the extent to which all staff in the program have been trained in case management protocols and adhere to its guidelines.

Staffing

As mentioned, until recently the staff consists of three teams of case managers each headed by a team leader. None of the three team leads had a background in mental health or addictions services. This led to challenges in supervising direct services staff and addressing service delivery problems with clients. Most of the direct service staff had a BA level of education (a few had a diploma in human services or social work), but lacked substantive training beyond this degree. Although there is a training program for front-line workers in agencies serving the homeless (offered at the University of Calgary and sponsored by the CHF), the agency has not taken advantage of this opportunity and most staff receive their orientation and training on the job.

Supervisors lack substantive training in the homeless sector. This situation is wide-spread across all homeless services organizations and is indicative of the lack of investment in training and supervision of front-line staff in the field that appears to be pervasive in the homeless services secto0r and not limited to Homebase or other Alex Health Centre programs. The extent to which a program provides a supportive team approach, with regular and frequent team meetings has been demonstrated to be important supporting staff (Olivet, Grandin, & Bassuk, 2010). These meetings require regular supplements with staff training and development in all areas of client understanding and service delivery. This is one area where the program could be enhanced.

Client involvement in program operations

Staff are not recruited from client rosters and no clients are employed by the program. There are no committees or groups comprised of clients which act in an advisory capacity to staff. Some client satisfaction measures are collected as part of its mandate with the Calgary Homeless Foundation, but the program lacks a feed-back mechanism to include consumer feedback and involvement in program operations and decisions. The program operates strictly as a service delivery model providing a discrete set of services *to* (not *with*) clients. It is not clear if this is by program or agency policy, but may flow from a health care delivery model which provides services to clients and does not need or encourage participatory efforts with clients.

Organizational culture/climate

It is difficult to assess the program's culture and climate at this juncture. It is a fairly young program but has developed an ethos wherein client requests and demands were generally responded to, even when this may have been in conflict with staff safety and well-being. One reported example is of staff expected to meet alone with a client who poses safety risks because of erratic behavior. A laissez-faire leadership style of the original program director appears to have resulted in client needs and preferences dealt with at organizational and staff expense. Thus numerous re-housing efforts have been necessitated because of client dysfunction, as process which absorbed resources and made it impossible to fund additional services for an expanded client load. The Alex management has come to recognize this as a problem area and has made efforts to change the leadership and shift operational practices. It is premature to assess the impact of these changes.

Significant staff turn-over has been noted and may be related to both the previous leadership style as well as the lack of training and in-house staff development both of which can support staff. Burn-out has been anecdotally reported, and attributed to the ceaseless demands of some dysfunctional clients. However, research that suggests the

impact of supportive clinical supervision on reducing burnout (Acker, 2012) implies that Homebase may fare better with new leadership that focusses on this. Unlike the Pathways program, Homebase does not have the funding or resources to support active and intensive staff training and support activities that could act as a preventative measure to mitigate burnout.

Staff demoralization also appears to be influenced by the (accurate) perception that the Pathways program is more fully resourced with in-house medical and psychiatric staff while Homebase has to find these resources in the community, enduring wait lists for psychiatric and medical services that leave staff coping with mental health emergencies without professional assistance. While this inequality results primarily from differences in funding provided by the CHF, at the front-line staff are less aware of that level of detail and more impacted by the difficulties in obtaining supports for clients in the community.

At the same time, there has been an uneasy tension between the two housing programs resulting from the belief by one (Pathways) that it deals with the most difficult clients and by the other (Homebase) that its client population is peopled by many with the intractable problems created by those with personality, mental health and addictions dysfunctions. Until the present study, there has been no opportunity to determine the differences in level of function and distress between the Homebase and Pathways clients. This the client level analysis provides insight into the extent to which these perceptions are accurate.

Programmatic changes

During the course of this project, Homebase has begun some substantial program changes. Fuelled by the departure of the first program director, a new program head has begun to introduce some tighter policies and procedures. They are not completely formulated and thus it is premature to comment on what impact they will have. Some issues and challenges relating to staff training and availability of other agency resources may extend beyond this change.

Houselink

Overview

One of the first housing programs established in Canada by concerned citizens on behalf of mental health consumers who were impacted by deinstitutionalization, Houselink has been providing consumer oriented and involved housing for over 37 years. Founded in 1976, and incorporated in 1977, it has served the mental health community in Toronto with a philosophy of "housing as a right" from its inception. Unlike many programs that identified those served as clients, Houselink saw its mission as housing, not treatment and has always used the term tenant (or member as each tenant is a voting member of the corporation/organization) who have a right to housing without other requirements: they are not required to adhere to treatment for either a mental disorder or addictions, nor maintain sobriety, and they are not expected to demonstrate readiness for independent living prior to signing a lease and placement in their own housing unit. Based on these criteria which are also articulated for housing first programs, Houselink can well be viewed as a front-runner in developing and supporting this model of housing vulnerable people who have experienced serious mental illness, with or without co-occurring addictions problems.

Houselink is an independent non-profit organization that is incorporated as a charitable organization in Ontario. It is governed by a board of directors (BOD), 50% of whom are agency tenant/members. It describes those housed as members of the organization, and offers them, in addition to BOD membership and voting rights for BOD positions, meaningful participation in all program activities, organization committees and opportunities for employment in the agency. This positioning of those housed both as tenants and members of the organization makes Houselink both unusual and leading edge in the delivery of housing services to those who have a serious mental illness, as it reflects the trend to have consumers included as meaningful peer participants in programs intended to provide basic life supports in living.

Beyond providing affordable, purpose built or rent-supplemented housing, other components establish Houselink not only as offering an unique *housing first* program, but one that also presents a model of program organization and functioning. Foundational to the agency is the meaningful and substantive inclusion of member-tenants in program governance and operation. Building on this is the organization's intentional development of a focus on building an intentional community of members, based on the premise that healthy communities make for healthy individuals and that community development links people together and builds on the strengths of individuals and groups. Recent wok in this area supports the importance of intentional communities for those with mental disorders (Pernice-Duca, Case, & Conrad-Garrisi, 2012).

The attention to the impact of organizational culture, what that entails and how it is infused throughout the staff and members of the organization is a second important focus within the agency. This area of organizational functioning has also received recent attention as an important aspect of agency health and well-being (Aarons et al., 2012; Waegemakers Schiff, 2009). These two aspects are based on a well-articulated implementation of a recovery-focus for all members. It is unusual to find a program that has integrated all of these aspects into its organization and service delivery model.

Mission

Houselink is a single purpose organization whose primary mission is the successful and stable housing of persons who have experienced a serious mental illness. The agency's governance manual states the following:

> ***Mission Statement & Principles***
>
> *Our mission is to improve the quality of life of psychiatric consumers/survivors including those who are homeless or otherwise marginalized, through the provision of permanent affordable supportive housing and programs.*

Under this mission statement the organization articulates distinct operating principles:

Houselink is committed to the following principles:

1. Housing is a fundamental right.
2. People have the right to be responsible for themselves and their own destiny.
3. People have a right to a positive culture for healing and recovery.
4. Houselink is member driven, and each member has the right to participate and share in the organization.
5. Houselink is a community in which mutual support and mutual accountability are fundamental.
6. Houselink is a community where racism, violence, sexism, homophobia and any other violations of the Human Rights Code are not tolerated.

Agency structure:

Houselink is a single purpose organization devoted to the housing of those with a mental disorder, with or without additional disabilities (addictions or physical disabilities). It serves adults over the age of 16 and has no upper end age limits. However, it is beginning to address issues that arise in its older tenants who are requiring additional support services. An intake worker works to place those referred into housing units (acceptance is based on availability of units and tenant-member needs) and supportive housing workers are assigned to individual member-tenants who provide instrumental assistance to individuals in acquiring stability in their residence. Beyond initial settling in, member-tenants are not required to maintain an active relationship with their support workers (most do so). In the event they do not keep active contact, an eviction prevention approach is practiced by supportive housing workers wherein they periodically check-in with these clients to assure that they do not encounter problems that will lead to eviction. This arrangement has been an important aspect of helping members to maintain housing. In addition to the housing staff, the agency operates several support programs to assist member-tenants: social/recreation, employment/education, food (community kitchen and bulk food buying), art and community development.

Houselink receives its support funding from the Toronto Central Local Health Integration Network, and the housing and rent supplement funds from the Ontario Ministry of Health Ministry and the city of Toronto.. This funding is supplemented by both institutional and a private donation and grants. Some smaller fund-raising activities help support program activities not available through its main funders.

As a single purpose agency, all of the organization's structure is focused on this mission. Thus there are no separate departments or additional programs that divert from this objective. Direct services are administered by four teams of supportive housing workers each consisting of between six and ten persons. Each team serves a specific geographic area and designated housing sites within those areas. In addition to the support teams, a program team supports the variety of community development, social-recreational and supported employment activities. Teams coordinate activities and housing support workers provide after-hours emergency coverage on a rotating basis.

Housing and landlord relationships

Over the course of 37 years Houselink has acquired almost all of its properties using public funding. The result is a portfolio of 22 buildings plus supplementary private market units that together house 486 persons [4](2013). At any given time, about two-thirds of all tenant-members are housed in agency owned units. These buildings consist of small (less than 30 units) apartments, communal homes (co-op) that house individuals in separate bedrooms while sharing common spaces such as kitchen, living/dining room and bathrooms. The agency also leases some rent-subsidized apartments in scattered sites throughout its service area (central Toronto). The co-op houses are frequently found in gentrified areas where they are a substantial positive contribution to the neighborhood. In all cases, with both owned and leased units, the agency acts as the landlord, and member-tenants sign a lease with the agency. As much as possible, the agency utilizes its maintenance budget to directly provide job opportunities to members (ie. Landscaping crews, garbage removal,

[4] This total includes family members and dependent children

cleaning), or indirectly by contracting with social-purpose enterprises that employ psychiatric survivors (painting, snow removal). Houselink provides all the maintenance, both interior and exterior, with the exception of normal household cleaning which is handled by the house tenants themselves and by house tenants through communal agreements.[5]

Staff

Direct service staff consist of persons with human services background and experience. The organization has an equity hiring policy and an inclusive employment strategy to help provide opportunities towards full-time employment for Members. As a result, a few direct staff were former tenant-members, and in a 2012 survey of staff, 51 of respondents identified as having personal lived experience with mental illness (52% response rate to the survey ie. 39 of 75 FTEs). Staff include supportive housing workers, community kitchen staff, social recreation and supported employment facilitators, as well as a community development worker and building maintenance staff who come from a variety of backgrounds including social work, recreation therapy and rehabilitation, as well as experience working in hostels, transitional housing and building maintenance. In addition, working with a private sector employment agency, Houselink employs about one quarter of its membership in part-time jobs. Members who seek employment as one of their recovery goals are actively encouraged to seek employment, as is appropriate, within the organization. Active staff development and support services are an integral component to the organization. The Board of Directors has adopted a variety of policies that speak to the philosophy of the organization (Recovery Policy, Community of Members) and the community development background of the executive director and the community development and clinical mental health background of the Director of Member Services and Partnerships add to this ability to oversee and provide staff support.

[5] This variation from a Housing first scatter site approach will be further explored later in this program description.

Direct service teams are supported by administrative staff as well as working with program staff who organize and oversees the numerous activities that contribute to building community and helping people keep their housing. These include social recreational activities; a supported employment program, an educational/vocational program – that provide and facilitates access to new learning opportunities for members and also facilitates employment opportunities both within and outside of the organization; and a food program to support the development of nutritional knowledge and healthy eating on a budget, as well as building friendships. Description of support activities follows later in this report.

Program Eligibility and Intake

Any person over the age of 16 who has a disabling mental health condition (is eligible for income supports because of a mental illness), disability, duration or diagnosis, with or without co-occurring substance abuse problems is eligible for Houselink housing. Intake is coordinated through a central intake process (recently changed in name to The Access Point) which handles all applications for supportive housing for those who have a mental illness and/or addictions problems. An applicant can elect to be referred to Houselink, but may experience a waiting period until a housing unit is available.

The Access Point intake provides an opportunity for an applicant to indicate what type of living arrangement is acceptable. While Houselink is able to provide many of these option because of its varied housing units, it does not provide all, and the waiting time for a preferred type of housing may not meet an applicant's need for urgent housing. Like all supportive housing providers in Toronto, this mutual choice is seen as important and the practice of "placing or parachuting" a new tenant into a building is avoided. Houselink does its own program specific intake interviews for those referred through the Access Point system. Those applicants who choose or are willing to live in a co-op/shared housing unit must then also meet with all residents of that shared home to determine acceptable compatibility. The agency has a well-defined set of protocols and practices to assure an acceptable housing match in co-op situation.

By agency policy, members may request relocation to another unit after being in their current location for a year. Reasons for this request are not a significant factor in relocation, but availability of a specific type of unit may be. Exceptions are made when a person is living in a co-op house and issues of compatibility within the house arise. While there is a well-articulated conflict resolution process, this may not necessarily be successful and a move may be the most feasible way forward. In these instances member-tenants do not have to wait the requisite year before relocation is implemented.

Program Description

The core of service offered is through the housing support workers who help each member to handle that challenges of daily living and address additional needs. Until stably housed, each member meets regularly and frequently with his/her support worker. The focus of this work is to help people keep their housing. This includes:

- Improve Quality of Life by assisting members in the development and use of informal (peers, friends and family) and formal supports (Supportive Housing Workers and other paid services) within Houselink and in the broader community to improve and maintain health, acquire, maintain and use skills and resources, and to aid their individual recovery plan;
- Community Development - to support and encourage member participation in Houselink decision-making and governance activities as well as involvement in activities within Houselink and in the broader community that promote and build stronger communities.

- Supportive Housing Workers participate in community development work as a means of promoting the goals of Houselink, fostering informal peer networks, influencing social change and promoting recovery.
- Problem-solving and crisis management - interventions to support community membership and to assist in the resolution of group-living problems. Interventions may include a change in involvement of the support system, skills in conflict management, accessing services for additional and urgent or emergency needs.
- **Landlord agent functions** - Supportive Housing Workers ensure members are informed of their tenancy rights and responsibilities, support members to meet their tenancy responsibilities, act as a liaison between housing-focused Houselink staff (e.g. maintenance, tenancy services) and the member, and review and report issues related to physical aspects of the housing.

As Houselink's members have aged over time (the average age of tenants is higher than in the general population), some now experience serious chronic health issues. In addition to these individual supports, the agency has also initiated several targeted supports for persons with chronic health conditions through a pilot project using telehealth to connect with home care nurses for those with chronic obstructive pulmonary disease and chronic heart failure.

As an organization dedicated to providing supportive housing, Houselink gears all of its activities to assuring that members are securely and safely housed and are then provided with social and recreational activities, personal development, and vocational, educational and employment opportunities. These activities include the following: a drop-in centre, food buying and preparation group, recreational activities on a weekly basis, monthly social issues group, poverty awareness campaigns, Wellness and Recovery forums 3x year, regular member education and training opportunities such as WRAP training including focus on employment and seniors, peer led conversations and information sessions, peer led activities, monthly Member Advisory Forums, General Members Meetings twice a year, and annual events which include holiday celebrations, the AGM (annual general meeting)and summer picnic. Houselink also sponsors The DREAM Team. This is a semi-

independent advocacy and education group that operates as an externally independent group whose membership is primarily peers who are advocates for safe affordable supportive housing for people living with mental illness with a focus on housing as a right . Houselink provides the legal structure and shares financial and management resources with the DREAM Team through a mutually agreed on arrangement.

Houselink Members

Houselink's organizational profile is unique in that way it blends the roles of clients and members of the organization. Each person who is housed becomes a member of Houselink. The term "client " is not used. This wording conveys the orientation of the agency to work in partnership with its service recipients to provide supportive housing while minimizing inequalities and eliminating, in so far as possible, services that are done to rather than with members. Members often wear multiple hats; leaseholder, operational committee member, Board of Director, part-time contracted employee. Members have been able to retain their member status, if desired, if they should leave the agency's housing program and move into different accommodation. This is an important aspect of continuity of services and supports as people who move on from a supportive housing program may continue to need extended supports through a transitional period and perhaps beyond. If these continued supports provide the additional assistance needed for greater independence then the program has provided an additional avenue for success.

This policy of continued membership is under review as the agency's mandate is to serve tenant members and it lacks the resources and funding to extend itself in a large way to those not under its housing umbrella. Up till recently, non-tenant memberships were capped at 100. This cap has been reduced to 50 to 75 and these limits are under review.

What is notable about Houselink membership is that individuals who are not tenants seek the agency's membership because of the additional activities and support services offered.

This voluntary participation has been noted as a feature of Clubhouse programs[6] but is not found in other housing oriented programs where eligibility is restricted to those receiving housing services (J. Waegemakers Schiff, Coleman, H., & Miner, D. , 2008). The importance of program acceptability to clients (members) is a critical barometer to appropriate services and should serve as an important hallmark for funders.

Because Houselink has been in operation for over 37 years, it has a history of member/tenant retention that the other programs are not yet able to document. Out of a total of 486 current tenant/members, over 85.6% have been housed for over a year. Because Houselink has seen, over the last decade, a rise in available units that it can support, the numbers provided below do not indicate a true retention rate because they are calculated on total units as of 2014 and not on total as of 2004 or 2009 (five and ten year markers). That is, 54.7% of the current clients have been stable house for more than 5 years, but this is based on a total count of 489 residents in 433 units whereas five years ago the number of available units was 389[7], and thus the retention rate of that five year plus cohort is even higher than the following chart indicates..

Years at Houselink	Count	Percent
Less than 1	69	14.2
1 to 5	156	32.1
5 to 10	139	28.6
10 to 20	94	19.3
More than 20	28	5.8
Total	**486**	**100.0**

[6] Clubhouse, a psychosocial rehabilitative program in existence for over fifty years, is found in industrialized countries (U.S., Canada, Sweden) and developing countries (Pakistan, Bosnia). It is based on voluntary participation and does not have or insist on involvement in clinical psychiatric services as a condition of membership. (J. Waegemakers Schiff, Coleman, H., & Miner, D. , 2008)

[7] Data on the exact number of residents/tenants is not available at this time.

Program Policies and Procedures

There is an extensive documentation of agency policies and procedures that are openly available to staff and members. A member/tenant handbook provided to each new tenant and each staff person, details in summary form, all policies and procedures relevant to a member's housing and status in the organization. These procedures also cover issues such as snow removal, heat hazard days, membership expectations in a housing unit and in the organization (for non-resident members).

Houselink is the landlord for all tenant/members and operates under the Ontario Residential Tenancies Act. This legislation has specific procedures for dealing with landlord/tenant disputes and evictions. While evictions are few, (reported at less than 1.5% of all housed individuals in 2013), most occur for failure to pay rent. Another 11 persons moved out after breaching their tenancy/lease agreement. Lower eviction rates may also be due to Houselink's type of supportive housing – where the landlord is also the support provider. That is, even if a client or tenant refuses or 'fires' supports (as with case management services) Houselink support workers can reconnect with a client 'as agents of the landlord' when tenancy or housing is in jeopardy. Houselink reports a consistently low eviction rate of less than 3% over the last ten years. These low numbers may also reflect the centralized intake service whereby a person can refuse to consider housing in a participating agency, thus leaving those committed to the agency's philosophy and operating style as well as housing location in the centre of the city (as opposed to more distant eastern and western Toronto locations).

Houselink as a housing first program

By definition, programs with a *housing first* philosophy place priority on housing and individual, without requirements of treatment compliance or sobriety from alcohol and drugs. Supports are provided in locations separate from a person's place of residence and are available directly of by formal agreement with another service provider. Housing is

both affordable, usually through the provision of rent supplements and tenancy is not time-sensitive. That is, a person can stay as long as he or she wishes. Housing is also by choice – that is a person chooses, within limits of affordability and availability, the type and location of their housing.

The above descriptors can accurately be applied to Houselink, with one caveat. Where Houselink deviates from formal program standards promoted by *housing first* programs such as Pathways to Housing in New York is on how the type of housing available and the supports in place to maintain housing. Those promoting *housing first* programs emphasize the importance of scatter-site individual housing units. Programmatically, this was the only viable option to congregate care available in New York where this program originated. However, it is based on a presumption that this model is preferred by all mental health consumers. In contrast, the housing options in Toronto are more diverse and also reflective of a city where large, turn of the century (19^{th}/20^{th}) homes provide for affordable co-op living. Pathways to Housing in New York City has also not had the benefit of 37 years of operation and opportunities to acquire its own housing stock. Thus it remains at the behest of private landlords, a situation that has both advantages and some serious disadvantages as housing availability and affordability cannot be guaranteed beyond the term of an existing lease. In contrast, Houselink as landlord and most often owner, can assure a stability of housing availability and affordability for units under its ownership.

Assertive outreach programs such as the Pathways models, will commit to re-housing a person when the initial housing arrangement fails. These guidelines to not specify the number of re-housing attempts that are realistically possible and affordable as each move requires funding allocation that deprives a new applicant of a housing opportunity. Houselink, as landlord or lease holder, has a number of safety mechanisms to keep people from losing their housing, including mediation, eviction abatement processes and relocation to another housing unit. However, it also has clear guidelines on re-housing those who have been evicted for non-payment of rent or lease violations. Thus its commitment to re-house is more limited than programs that will seek a different landlord in the hopes that a new location and new tenancy will provide stability.

Aside from the type of units available, Houselink also differs in the organization of housing supports. This organizational design stems from the fact that the agency has always seen itself as a housing agency supporting persons with mental illness disabilities to stay housed. Housing workers are required by the funder to conduct a Common Assessment of Need with the new tenant within a month or two of move in and reviewed every six month intervals thereafter. Direct mental health and addiction services are available through both informal and formal arrangements with neighborhood agencies specializing in these services. Ancillary social, recreational, employment and skills building activities are offered on at agency offices and various building locations and accessed on a voluntary (not compulsory) basis. This organizational structure meets the criteria for services offered off-site (of the housing unit) and by formal agreements with other providers.

In some domains Houselink exceeds other housing first guidelines and sets high standards for peer involvement in the organization. Its governance and programs are explicitly and implicitly geared towards a recovery from mental illness and addictions. It integrates members into its operations and governance in significant and meaningful ways, and it strives to achieve an organizational culture based on respect and inclusivity. It also formally recognizes the importance of community in the recovery process and has worked to intentionally build community both within the organization and at those housing locations where a discrete group of individuals make this feasible. As the mental health services sector has begun to recognize the importance of community and a sense of belonging for persons with a mental illness disability, Houselink sets a standard in community building that deserves recognition.

The Alex Pathways to Housing

Pathways to Housing (Pathways) is one of two *housing first* programs under the organizational auspices of the Alex Health Centre. The Alex is a multi-program health care agency whose mission is: *delivering innovative and accessible health and social*

solutions. It has been in existence for over 40 years, has a tradition of providing health care services to inner-city impoverished areas, and focuses on providing primary medical care and housing support to some of Calgary's most vulnerable persons through addressing both health and social issues. In 2006 it was asked by the Calgary Homeless Foundation to participate in the development of a *housing first* program for the city's most vulnerable and hard to house: persons with a mental illness and co-occurring substance abuse. This led to the development of Pathways to Housing as a comprehensive program that included housing and supports provided by an assertive community treatment team. The program began operating in 2007 and at this time services over 170 clients.

Program Description:

Pathways operates as a separate and distinct program within the Alex organization, utilizing its own dedicated staff for service delivery. Staffing and resources are not shared among programs and agency clients served by other programs must adhere to a uniform intake process established for the program. Initially, the Homebase and Pathways programs occupied the office space in a shared site. A year ago Homebase relocated to its own space about one km from the Pathways program.

The Alex has recently added another program with a *"housing first"* orientation which is geared towards meeting the complex needs of chronically homeless persons who have major medical impairments, chronic substance abuse and (often) a mental illness. This program, which began under Homebase supervision, is now under the management of the Pathways program director. Although this housing program is not included in the client level of analysis, it is important to include in as a reflection of the Alex Health Centre's commitment to expand housing programs for vulnerable and disadvantaged persons.

When first opened, Pathways was located in a light industrial area close to the city's central core and easily navigable from other homeless services. Five years ago it relocated and at this time, its base of operations is a distinct set of offices in a store front and light industrial area of Calgary, in the southeast quadrant of the city, well away from the city's

core. Clients are seen at these offices, but in addition, much client contact is in other locations in the community which are of travelling convenience to clients. The program offices include a full medical clinic, counselling and activity rooms and space for vocationally oriented activities. Clients are encouraged to come to the offices and avail themselves of a variety of services and activities.

The extension into housing and supports to persons with mental illness and co-occurring addictions was an extension of the overall mission of the Alex since it included the availability of a medical clinic, with attending physicians and psychiatrists, at the program offices. Although the P2H is not a residential program, the assertive community treatment team (ACT) approach includes availability beyond customary business hours. The provision of an ACT team entailed extending into a program offering 24/7 support services. This extension of service availability necessitated organizational flexibility regarding staff and support. A program of intensive staff training was initiated to assure that those providing front-line serves understood and supported a rapid "streets to housing" philosophy and action plan, and were also conversant in the multiple overlapping mental health, physical health and addiction problems facing clients. It maintains a separate profile from the other Alex programs which are located some distance away from this program. While accessible by public transportation, it is not near the city's rapid transit lines and is thus not as accessible for those with health and mobility impairments.

Housing

All Pathways clients are housed in apartments in various locations throughout the city. Leases are negotiated directly with clients, who are the lease holders. Staff assist in the process and act as a liaison with landlords. Rent deposits and rental supplements are made available through funding from the Calgary Homeless Foundation (provincial housing supplements). The program does not own any rental units and does not hold the lease on any units. Housing is scatter-site and case managers make every effort to avoid housing in buildings that already have a number of other clients. The program does have five

apartment units allocated in one building designated for those disabled by a mental illness, but these are reserved for those who have specifically requested this type of accommodation.

Referrals and Case Assignment

Individuals are referred by any of the local agencies which serve the homeless or can be self-referred. Until late 2013, Pathways conducted its own screening and intake. It has recently moved to participating in a centralized intake process, which consists of the major housing providers under the Calgary Homeless Foundation funding umbrella. Following the generally screening and assignment, the program conducts an agency-specific intake and upon admission, the client is assigned to one of three teams ACT teams depending on their previous mental health and justice system history. Within the team, staff coordinate efforts and clients are regarded as team clients rather than the responsibility of one designated person (see contrast with Homebase staffing).

When a client is assigned by the intake screening committee to Pathways he/she undergoes an extensive psychiatric screening and assessment to determine eligibility. This assures that only those with severe disabling mental illnesses are admitted to the program. After intake and team assignment a specific, individualized housing and support plan is implemented with client participation and consent. Beyond housing supports consisting of regular meetings with an ACT team staff, clients are not expected to engage in other program activities, however, they are encouraged to do so.

Discharge

Discharge from the program was not part of the original Pathways organizational framework. The supposition, both locally and with the originating Pathways to Housing in New York City, was that clients would need program support for an indefinite period of time. This assumption is now being questioned, as some clients who have been stably

housed for up to 7 years no longer require the level of intensity of supports that were imperative when they were first housed. However, there is little research as to what criteria should be applied in deciding when a client no longer needs the intensive services of an ACT team to maintain housing. Additionally, those who are in a stable housing situation may need some less intensive supportive structure. They will also, in most cases, continue to need the rent supplements that make their housing affordable. Thus, the issues of discharge because an individual has reached a level of stability in his/her life is a developing challenge that the current program structure has not addressed. Concomitant with this is the fact that for a significant, but unknown, number of clients the support offered by Pathways may not be replicable if they were forced to transfer to another organization or program. In other words, some of their achieved stability may be due to the consistent and constant presence of a support structure provided by the ACT team model.

Discharge for failure to maintain stability within the Pathways program has been an avenue for a few clients who fail to be able to work within the program model. As with the parent program, Pathways experiences a failure or drop-out rate of around 13 – 14% of those admitted. Roughly one in every eight clients fails to succeed in housing stability in the Pathways program. There is at the present time, no data that profiles those who drop out, who comprise much of this cohort. Those who are asked to leave the program by Pathways staff constitute another small, but noticeable group. They appear to the individuals whose addictive lifestyles lead to anti-social and illegal behaviors that result in repeated evictions by landlords. Hopefully, forthcoming data will provide greater insight into this cohort.

Program philosophy and operating principles:

The Alex P2H program is built on the *housing first* philosophy that housing is a prerequisite for rebuilding a healthy life, that people are more able to engage in positive steps towards addressing mental health issues when their need for appropriate housing has

been met, and that successful engagement is built on relationships and not predicated on coercive actions. It is a service delivery model where professionals and trained paraprofessionals deliver a set of core service with housing as foundational to other services. While peer involvement in this model is stated, those with lived experience play a supportive by secondary role in this service delivery organization. The organization is also built around respect for staff and the need to support staff in their outreach efforts.

The program serves clients with severe mental illnesses and co-occurring substance abuse who have been homeless for at least six months. It thus aims to house those is most dire circumstances, although its capacity to help those who have additional serious health concerns and disabilities is limited. It has designated teams for those who have additional justice system involvement[8], either through admission diversion away from jail, or planned housing for those with a serious mental illness who are released from jail.

Since its inception, the program has twice experienced a change in top leadership. However, the current director of the program has been with the program from the beginning and has developed a well- articulated program design and staff support philosophy. Program design entails the incorporation of *housing first* principles with modifications to fit both a Canadian and Calgary health and social service delivery system while maintaining fidelity to core Pathways to Housing guidelines.

The program promotes the availability of direct contact as many times as necessary to help a client achieve and maintain housing. Unlike its American counter-part, which is constrained in its service payments by American Medicaid regulations as to the number and frequency of client contacts, the flat-funding model in Alberta allows for as many service units as necessary. Thus staff can provide numerous contacts in the course of a month, as indicated by client need. This funding model allows for, if necessary, multiple housing moves until the right client fit is achieved, and/or the client is finally able to settle into a stable environment (this sense of permanency can be anxiety-producing for persons

(Waegemakers Schiff, J., Coleman, H., & Miner, D. , 2008)[8] Houselink also has justice system funding to house, both pre and post incarceration, those who have been involved in this system.

who have only known an iterant life-style and need time to make attitudinal and behavioral changes). The program staffing also has ready accessibility to psychiatric services for medication modifications as needed. This availability is for some, fundamental to achieving medication compliance, as many choose to discontinue anti-psychotic medication rather than endure unpleasant side-effects, or alternatively experience no salutary benefits of these medications.

Services available on-site include that of a medical clinic staff by three psychiatrists, three physicians (medical), a nurse practitioner, six registered nurses, social workers, mental health case managers, a recreation therapist and a nutritionist. In addition to outreach services, wherein clients are contacted at their place of choice in the community, the program offers a number of office-based services including groups on mental health (illness management and recovery), substance use and support, cooking and nutrition, recreation and social activities, as well as specific services of computer skills training, vocational/employment assistance, and a legal (justice) walk-in clinic.

In accordance with Pathways to Housing program principles (Tsemberis, 2010) the Alex P2H operates under the following additional principles:

- Housing is in a location and structure that is acceptable to the client. Housing is situated throughout the city and not restricted to certain locations. Choice and availability are predicated on market availability. In Calgary housing choice is limited and has been more restricted since massive flooding reduced the availability of rental units. Housing is controlled by the client through standard landlord tenant agreements and is not time-limited. Clients live in separate housing units.
- The program does not mandate any demonstration of readiness to live independently. Nor does it require attendance at any remedial or treatment program. However, support and treatment services are readily available at program offices. This reduces wait times and barriers created by services that are not conversant with serving seriously mentally ill clients.
- Clients who lose their housing are re-housed immediately (depending on dwelling availability).

- Engagement of clients is individually oriented and non-coercive, using approaches to encourage participation in health-oriented activities and developing new living goals. Mental health and substance abuse services are available but not mandated by the program. The program employs a harm reduction approach, supporting reduction of harmful substance use rather than requiring total abstinence, and does not require abstinence from substances in order to be housed. Motivational interviewing is used to address serious substance use issues and complications. The approach to client engagement is through assertive engagement, a process which has been carefully documented.

Staffing

The Alex P2H staffing consists of social workers, mental health case workers, a psychologist, nurses, physicians and psychiatrists as well administrative support staff. Direct service workers are assigned to an ACT team which is supported by the medical and psychiatric staff. At the present time there are three ACT teams, the newest having been inaugurated in 2013. Each serves a distinct sub-population: a hospital team that serves those referred from within the Alberta Health Services system, a justice team serves those referred from within the justice system (intended to direct those needing mental health and support services away from jails and prisons), and a team addressing the housing needs of high service users coming from both corrections and hospital services. Clients are screened at the central intake process recently inaugurated by the Calgary Homeless Foundation and referred to the appropriate program. Within the three teams, there is client capacity for 200 persons. At the present time, over 170 persons are housed. Program capacity is determined by a combination of the case load each team can accommodate and the housing subsidies that accompany each client.

The Calgary Homeless Foundation, which funds both Pathways and Homebase, introduced a detailed case management guidelines document with the expectation that all funded programs would assure that staff are trained in case management protocols and procedures.

While this is progressing, it is unclear as to the extent to which all staff in the program have been trained in case management protocols and adhere to its guidelines.

The program operates from offices located in an office and mixed business use location in the southwest section of the city. Although well-served by bus transit, it is distant from the mass transit system and thus access is a more lengthy process for those relying on public transportation. The positive aspect is that it is amidst multiple grocery stores and inexpensive eateries. It is also well away from the city's central core where there is an overabundance of homeless persons congregating around large city shelters and soup kitchens. This location helps clients who are seeking to remove themselves from the negative influences of street life in certain areas of the city.

Landlord relationships

To date, the Alex Pathways has been able to establish and maintain positive landlord relationships in what has been a very tight and competitive housing market. The agency is leaseholder in some instances and is the lease negotiator, with the client as lease holder, in others. The program is still not committed to either approach as its sole means of working with the housing market and continues to evaluate which approach is best for the organization and clients. The intensive and frequent supports by the ACT team have forestalled potential difficulties and minimized the number of clients facing eviction. With increasing rents and a very competitive and shrinking rental market, maintaining positive landlord relationships has become a priority for the housing specialists who oversee this aspect of the program.

Program activities and client inclusion

In addition to the clinical services provided by the staff psychiatrist, physician, nurses, social workers and psychologist, the Alex Pathways offers a number of life-enhancing and social skill-building activities that clients may participate in, at their choosing. While none

are mandatory, case management staff encourages clients to participate in programs that include: recovery and illness management, wellness (recreational and physical activities), the challenges of addictions, food preparation and management, as well as a peer support and family peer support program. Pathways has become pro-active in encouraging clients to move towards recovery activities and staff note that increasingly clients are moving in this direction. The family support group has also been instrumental in connecting clients with relatives that they had lost contact with or been estranged from. The program has also introduced some culturally oriented activities, having sponsored Aboriginal healing circles, sharing circles and a pow-wow. This culturally specific component is not present in the other programs in this study. It continues to seek ways to provide programming relevant, appropriate and of interest to clients.

Staff Training and Development

The highly intensive and individualized services of a *housing first* program place a heavy demand on staff. Burnout and turnover in programs serving mentally ill homeless persons has historically been high. The extent to which a program provides a supportive team approach, with regular and frequent team meetings has been demonstrated to be important supporting staff (Olivet, McGraw, Grandin, & Bassuk, 2010). These meetings require regular supplements with staff training and development in all areas of client understanding and service delivery. The Alex P2H programs has developed a strong in-house staff training program which has included: immersion in *housing first* principles and client approaches, integrated dual disorder approaches, self-defense, dealing with client death, working with clients who are actively using, trauma-informed treatment approaches, hoarding behaviors, motivational interviewing, aboriginal awareness and cultural diversity and substance harm reduction including stages of change approaches. This commitment to training and team work has had a significant positive impact on pathways staff. Burnout is not reported as a significant issue and this is supported by a low staff-turnover rate (this relationship is supported in the research literature (Hopper, Bassuk, & Olivet, 2010).

The program's commitment to staff development has also resulted in numerous presentations, both for specific training and for general information, at conferences and to out of town organizations seeking to establish a *housing first* program. This external recognition of the positive impact of the Alex P2H programs by other organizations in different provinces also adds a positive message to staff as they are involved in the development of specific approaches that are effective in a Canadian context.

Pathways to Housing Edmonton

Organizational Auspices

The Pathways to Housing program in Edmonton is under the organizational umbrella of the Boyle McCauley Health Centre, a community-based health centre that has been operational in downtown Edmonton for over 35 years. Boyle McCauley operates under the guiding principles of "offering accessible, comprehensive, culturally sensitive primary care, provided by people who are willing to look at the whole person and include that person in decisions about their health care". Its focus, prior to extending into supportive housing for those with a mental illness, was comprehensive medically oriented care for the local, low income community. The addition of a *housing first* program for those with a serious mental illness and co-occurring addictions in 2009 was an expansion into mental health and psychosocial interventions. The stated mission of the organization continues to be the same, with a focus on primary health care.

In 2009 Homeward Trust, the Edmonton-based supported housing agency leading the implementation of the Edmonton 10 year plan to end homelessness, invited Boyle McCauley to develop a *housing first* program modeled after that developed in New York (Tsemberis & Asmussen, 1999)[9]. While Homeward Trust funds several programs with a *housing first* philosophical orientation, P2H is the only one which is specifically mandated to serve the needs of those with co-occurring mental illness and addiction problems. Program mandates also include that those served have a documented history of 6 months or homelessness, or are being discharged from a psychiatric facility after an extended hospitalization. The program was established at an independent site, not far from the main Bole McCauley health centre offices.

[9] See Appendix A for a description of these elements

The parent organization, Boyle McCauley, is overseen by a board of directors which operates under a governance model and has little direct contact with the day to day operations of Boyle McCauley programs. While the Boyle McCauley programs each have a program director who reports to the Executive Director, the P2H program has an director who operates in a semi-autonomous manner from the rest of the health centre programs. This has resulted in a close relationship with Homeward Trust and P2H Edmonton has been allowed to develop in close cooperation with its primary funder.

Program History

The initial challenge of the program was to develop operating procedures that met *housing first* guidelines (Gilmer, Stefanic, Ettner, Manning, & Tsemberis, 2010). A survey of the program in 2011 by the New York based Pathways staff confirmed strong adherence to this model. P2H Edmonton operates primarily as a free-standing program with its own dedicated executive director who reports to the Boyle McCauley CEO. Its organization is in line with the guidelines for a *housing first* program, which includes a full ACT (assertive community treatment) team of 8.0 FTEs, and has a part-time psychiatrist, medical doctor, mental health and substance abuse outreach workers, and occupational therapist under a team supervisor. This team is responsible for the assessment and service delivery of psychosocial and mental health supports for clients. Housing supports, including rent agreements and payments, payment of utilities, assistance with move-in and out and minor household repairs, is handled by a housing support worker who works alongside the ACT team. The team serves, at full capacity, 77 individuals, some of whom are parents living with dependent children.

Program activities consist primarily of individual support sessions, most frequently as outreach calls or home visits to clients. Clients are seen at the office for medication and psychiatric consultation appointments. Some substance abuse counselling is provided, but the substance abuse specialist is primarily involved with front-line outreach and client

contact work. There is minimal use of groups, with only one ongoing group which addresses parenting issue for those who have children currently offered.

Program Philosophy and Mission

Under the umbrella organization which espouses comprehensive and inclusive health services to the inner city of Edmonton, Pathways is mandated to provide intensive supportive housing services to persons with disabling mental health and addictions problems. It operates under the guiding principles of *housing first* for this client population established by Pathways in New York City. It does not serve those whose primary problem is addiction, and refers them to other programs in the city.

Leadership

Pathways Edmonton was developed and led for its first four years by a social worker with substantial mental health experience. The founding program director at Pathways Edmonton left for an out-of province position and was replaced by a person who had a legal background as an attorney but no mental health, addictions or social services delivery background prior to assuming this position. The learning curve required to meet the challenges of vulnerable persons with complex problems has been quite steep and it is premature to assess how this change will impact the operations of the program.

Formal Organizational Components

The main purpose of the program is the rapid housing of persons with a serious mental illness and co-occurring substance abuse problems, without requirements of treatment compliance or sobriety to maintain housing. Pathways Edmonton follows the organizational policies and protocols of its parent organization and those protocols placed on it by its funder, Homeward Trust. Program specific policies and protocols are more

loosely developed. Many practices are informally in place and serve as operational models, but have not been formally established. These policies, which deal with client/program relationships and responsibilities, extend from how landlord relationships are handled to what circumstances will lead to a person's discharge from the program. Those policies and practices that are more clearly articulated address the program components delineated for housing first programs.

The main program components consist of an ACT team which has nursing, medical, and psychiatric staffing components. The direct case management positions are filled by persons with a variety of human services training and background. Few have had prior experience with a client population characterized by serious mental illnesses and addictions. This lack of experience has been an organizational challenge as training opportunities and supervision specific to this client population have not been able to be adequately addressed. The presence of a researcher on staff has been a strong support to identifying organizational successes and challenges. A recent review of the extent to which the staff were able to function as a team has highlighted some of the training areas that will improve the organization's operations.

Staffing

The lead person on the ACT team has no mental health and addictions experience. This, along with a new director similarly lacking in substantive experience in working with this vulnerable population, has led to challenges in staff supervision, training and support. Program staff consist of persons with a background in social work, psychology, and rehabilitation studies although hiring criteria have not required experience in working with seriously mentally ill persons. Direct service staff are assigned to the ACT team which consists of six staff and at present serves 75 individuals. This staffing ratio is comparable to that found at Pathways programs elsewhere and matches the need for intense services with optimal caseload assignment. The direct staff is supplemented by a nurse and part-time physician and psychiatrist who address the medical and mental health needs of clients.

Client Admission Criteria

Eligibility for the program includes being homeless, the presence of a major psychiatric disorder which has resulted in impairments in employment and living. Substance abuse if often co-occurring and as a result the program uses a harm-reduction approach to helping clients minimize the adverse effects of their addictions. The program has few exclusions. One is the presence of an addiction without a co-occurring mental illness. Justice system involvement does not preclude admission, nor does a history of acting-out behavior. However, the program is working on guidelines for accepting those with serious anti-social and behavioral problems as it has encountered a number of instances where these persons are unable to maintain any housing.

Referrals and Client Assignments

Pathways Edmonton accepts referrals directly from local service providers and organizations. It maintains a waitlist of those requesting services but does not initiate an intake process until there is space within the program for a new admission. At intake, applicants are screened for a history of mental illness and a complete assessment of need is established. Medical and psychiatric evaluations become part of this initial assessment process. Because intake interviews are only conducted when a living space becomes available, the move from initial interview to housing is rapid. At the time of admission, clients are assigned a primary support worker who assumes responsibility for assuring that all aspects of the assessment are reviewed with the client and a mutually agreed on action plan is initiated.

Discharge Criteria

Homeward Trust, the organization that funds the Pathways Edmonton program, has a goal to discharge persons in its *housing first* programs in a year. To date, Pathways has not been part of this planned discharge process. Pathways Edmonton continues to face the

challenges of when a person should be discharged from its program. Some persons leave because they make alternate living arrangements. These are considered positive terminations. Others have multiple housing failures, due to evictions for a variety of reasons. The program has not established criteria for when a person has had an unacceptable number of housing failures and continues to struggle with handling those who repeatedly lose their tenancy. When people leave the Pathways program, regardless of the reason, they are discharged and any request for re-housing must go through the agency procedure for housing applications. Pathways does not provide support services to those who are not housed in its program and it does not have precise information on the reasons for discharge of all persons who leave its program. Thus it is not possible to determine the extent to which these discharges are for positive reasons as contrasted with those who are unable to keep to minimal program and tenancy requirements.

Recovery orientation and peer involvement in program

As with all Pathways model programs, the Edmonton Pathways states that it has a recovery focus for clients. However, it is difficult to determine the degree to which this orientation is applied by staff in individual contact or through programmatic activities. As Pathways has few activities organized for clients, most need to seek social, recreational and vocational activities in other organizations in the community. Because the extent of this integration is not documented, it is not possible to determine how far this extends to supporting recovery attitudes and activities.

Although inclusion of peers as role models and supports within programs serving persons with serious mental illnesses has been well-established (Davidson, O'Connell, Tondora, Styron, & Kangas, 2006), many formally organized housing programs fail to include peers as significant contributors. Thus Pathways Edmonton is the rule rather than the exception in its lack of inclusion of those with lived experience in its program organization and services delivery model.

Organizational Culture

As with most programs that are components of a larger organization, Pathways Edmonton borrows organizational culture elements from its parent organization as well as from the philosophy of its program mandate as a *housing first* program. As a component of a larger inner city health centre, Pathways sees delivery of a specific set of service to a target group of vulnerable and disenfranchised clients as its main mission. Service delivery connotes services that provide *to* rather than *with* service recipients and this implies a hierarchical rather than collaborative organization. The literature on peer involvement in mental health services suggests that a collaborative model is both more acceptable and effective and promote a recovery environment for clients Davidson et al., 1999; Mowbray, Moxley, Thrasher, Bybee, & Harris, 1996).

The extent to which the ACT team of the program is able to function as an inclusive and collaborative unit will have a strong bearing on the extent to which a collaborative environment exists within the organization. A recent audit of the ACT team indicated that there was a considerable amount of communication and sharing within the team and that this has contributed to higher levels of cohesion. The report recommended that increased integration of the medical staff would contribute to greater cohesion.

In small organizations and programs, leadership has a direct influence of the organizational culture and climate. The founding program director had a collaborative style of working with staff, which de-emphasized hierarchical structure and encouraged staff involvement in decision-making. It is premature to speculate as to whether this collaborative model will continue under new leadership.

Program Comparisons

This comparison of programs is intended to reflect on the similarities and differences in organizational design, program philosophy and operating principles. It will provide clarification on the ways in which they serve similar client populations in different and in some similar ways.

As a frame work to development of this report, the key organizational component used in program descriptions and comparisons were compiled into the following chart.

Program Comparison Chart

	Homebase	Houselink	Alex P2H	P2H Edmonton
Client profile	No prior formal identification of mental health problems; addictions not the main presenting problem	Mental health and co-occurring addictions	Mental health and co-occurring addictions	Mental health and co-occurring addictions
Referral source: Previous Present	front-line worker/agency centralized intake	Self, front-line worker/agency centralized intake	front-line worker/agency centralized intake	front-line worker/agency front-line worker/agency
Funding source	Calgary Homeless Foundation	Various provincial housing and justice departments	Calgary Homeless Foundation	Homeward Trust
Org Auspices	Alex Health Centre	Self-Standing NGO	Alex Health Centre	Boyle McCauley

				Health Centre
Organizational governance – Board of Directors (BOD) or advisory Board: governance or working board or distant from board	BOD governance. No program advisory committee	BOD - which consists of 50% member/tenants	BOD. No governance No current advisory committee	BOD governance. No program advisory committee
Client involvement in governance	no	yes	no	no
Service recipient involvement in operations	no	yes	no	no
MH Services at program offices or by referral	by referral	Supportive and informal counselling at the program, therapy through formal agreements with local agencies	at program	on site
Program activities: offered by program or linkage to local community	local community	program and community	by program	primarily in community
Case management model (ACT, ICM, CM)	ICM	Supportive Housing Worker	ACT	ACT
Client exclusions	No formal mental illness diagnosis, but may have co-occurring mental illness	must have mental illness diagnosis, or evidence of such through a disability and duration	must have mental illness diagnosis	must have mental illness diagnosis
Landlord arrangements: Program or client hold lease	client	Agency (program)	mixed	client
Length of service	2 years	Indefinite	not defined	not defined

Client discharge	voluntary move, , or unable to sustain housing - multiple evictions	by eviction or voluntary move	voluntary move or unable to sustain housing - multiple evictions	voluntary move or eviction
Program evaluation activities	yes	Yes	yes	yes
Explicit recovery orientation	technically NA as MI not a primary focus	yes - in governance and operational policies, members and staff trainings, and member-oriented activities	in policy. Difficult to ascertain in practice	in policy. Difficult to ascertain in practice
HF approach/philosophy	Stated in program policy; Not evaluated for compliance with P2H program standards	clearly stated in organizational policies, protocols and practices.	yes - evaluated with HF standards	yes - evaluated with HF standards
Nomenclature for tenants	clients	members/tenants	clients	clients
Self-evaluation	no	Yes	some	some
Client satisfaction surveys	no	Yes	no	no
Organizational culture described/identified	no	clearly articulated	not formalized.	no
Housing arrangements	scatter-site, client holds lease	mixed housing opportunities. Houselink is landlord or holds lease	scatter-site, P2H holds lease	Scatter-site, client holds lease.

Organizational structure and auspices

All four programs are affiliated with organizations that have been in existence since the late 1970's. The Calgary and Edmonton programs are distinct programs operated under the umbrella of a community-based health centre, - The Boyle McCauley Centre in Edmonton and the Alex Health Centre in Calgary. To the best of our knowledge, Houselink in Toronto is the only free-standing single purpose organization in Canada whose primary mission since its inception has been housing and providing supports to promote housing retention for persons with a psychiatric disability with a *housing first* philosophy and substantial peer inclusion in program and governance functions.

Three of these programs have been housing persons with mental health issues for at least as long as the At Home/Chez Soi sites approximately 5 years). The fourth, Homebase, operates under a *housing first* philosophy but has a mandate to provide housing for those not eligible for the Alex Pathways program (which is a diagnosis of a major mental psychiatric disorder). However, Homebase clients may have mental health issues and are perceived by program staff as being a group of very high demand individuals who may have significant underlying mental health and addiction problems. [10]

All these programs have additional advantages in being in mature organizations which have existing organizational structures to address program organization and delivery issues. However, Houselink is the only program which has been providing dedicated *housing first* services for over 37 years and thus has greater experience and depth in dealing with relevant housing and client related needs. Houselink has developed extensive documentation of its program philosophy, policies and practices as a result of its free-standing basis and need to have a well-defined organizational structure.

Organizational governance

[10] This will be further explored in the program demographic section.

There are differences and similarities among the four programs in program auspices, organizational design, philosophy and culture. Three are components of a larger community health care organization, while the fourth is a free-standing NGO with direct government funding. . The Alex Pathways and Homebase are under the oversight of the Board of Directors of The Alex Health Centre and the Pathways Edmonton program is under the Board of the Boyle McCauley Health Centre. Both boards are governance boards and operate at a distance from the day-to-day operations of their programs. All three programs have directors who report to the respective executive director of the organization. In each instance, the program directors have extensive independence in the organization and delivery of services. Liaison with external funders is handled as a mutual task of the executive and program directors. This freedom in handling operations has allowed each director to develop a vision for how *housing first* models apply within their programs. Neither the staffing nor the Board of Directors has a peer component thus there are not service recipients or former service recipients on the Board of Directors and any former service recipients are not specifically employed because of their prior status with the organization. That is, there is no peer model integrated into these organizational structures.

In contrast to the three programs offering services as an extension of a local health agency, Houselink is an independent non-profit organization governed by a board of directors (BOD), 50% of whom are agency tenant/members. It describes those housed as members of the organization, and offers them, in addition to BOD membership and voting rights for BOD positions, meaningful participation in all program activities, including directing, planning and running, organization committees and various opportunities for employment in the agency including supported employment program, transitional fulltime employment and transitioning from member to full time staff.. This positioning of those housed both as tenants and members of the organization makes Houselink both unusual and leading edge in the delivery of housing services to those who have a serious mental illness, as it reflects the trend to have consumers included as meaningful peer participants in programs.

Program Philosophy and Culture

All four programs operate under a *housing first* philosophy. That is, all are committed to housing as a priority, and not conditional on meeting organizational requirements for treatment engagement or sobriety. While the programs may reflect client rights and responsibilities in program policies and client manuals, the mission and philosophy of each program is a determinant of how these functions are implemented. Houselink is the only program that specifically mentions housing as a right as part of its organization's mission statement. Additionally, only Houselink specifically addresses the importance of recovery as a specific goal in its mission statement and also has an explicit recovery policy It also extends its view to include explicit mention of an inclusivity policy in all aspects of organizational life. This mission statement is also reflected in program activities and manuals that specifically incorporate this mission. The other programs lack this level of infusion of recovery in global statements.

Beyond recovery, Houselink also promotes the development and maintenance of an intentional community for its members. In keeping with literature which suggests that social inclusion in intentional communities promotes well-being and self-efficacy, belonging to a community also enhances social integrations (Mandiberg & Edwards, 2013; Waegemakers Schiff, Coleman, H., & Miner, D. , 2008.

All four programs offer rent-supported housing units in locations that are acceptable to clients, and provide support services as agreed-on with program participants. Support services are available and offered at the participants' locations of choice – home, office or community. Additional services offered by each program are office-based and not at the participants residences. One exception is that Houselink ensures buildings have community spaces (as part of its intentional community approach) and holds a range of activities, house/building meetings and educational events at various buildings. Two of the programs, both the name Pathways in their title, also operate under the *housing first* program model promulgated by Pathway to Housing in New York City. That is, they are

staffed by assertive community action teams and use a scattered-site individual housing unit model of housing. They are not time-limited and both have actively offered priority housing to those who are absolutely homeless (living in shelters and living rough). Supports are provided 24/7.

The other programs operate under a *housing first* philosophy but use different organizational structures in their operations. Homebase, which is not specifically targeted for those with a major mental health diagnosis, uses an intensive case management model of service delivery and services are only available during the work week (Monday – Friday, 9 – 5). Program duration is slated at one year of housing support, but to date has been extended for most participants as they require longer periods of time to stabilize their lives. On the other hand, Houselink, as a landlord and support provider, has teams of support workers and has an on-call system to handle crisis situations. It also has an eviction-prevention strategy whereby a tenant/member can "fire" or discharge a support worker and still maintain housing. In the event that the tenancy becomes problematic and eviction becomes a potentiality, the supportive housing worker's functions shift more to taking on a landlord function responding to the breach of the lease while at the same time continuing to offer alternatives. This eviction prevention process utilizes a specially trained staff person on tenancy law to help to intervene in the situation. It also has no time limits on length of tenancy and has some individuals who have been in its housing program for over 20 years. Finally, while Homebase, like the two Pathways programs, uses a scatter-site approach to housing, Houselink has an array of housing options, agency-owned and by lease agreement with other landlords that include single occupancy units, family units as well as some co-op units (sharing a house but with one's own unity) in houses.

The programs that operate as components of health centres (the Pathways programs and Homebase) operate on the basis of a service delivery model which connotes that its services are provided *to* rather than *with* service recipients. This implies a hierarchical rather than collaborative organization. It is reflected in the fact that service recipients are not part of service delivery or governance. The literature on peer involvement in mental health services suggests that a collaborative model is both more acceptable and effective

and promote a recovery environment for clients (Davidson et al., 1999; Mowbray et al., 1996). While this orientation has not been extensively investigated in its application to organizations that serve those with-out mental illnesses, it should be considered as an important component of the culture of an organization.

An examination of program orientation includes its focus on a recovery model of working with people. Peer involvement in recovery has recently become acknowledged as an important aspect of the healing journey. Service delivery connotes services that provide *to* rather than *with* service recipients and this implies a hierarchical rather than collaborative organization. The literature on peer involvement in mental health services suggests that a collaborative model is both more acceptable and effective and promote a recovery environment for clients (Davidson et al., 1999; Mowbray et al., 1996).

Of the four programs, only Houselink as a formal and inclusive policy on the inclusion of peers, as members of the organization, as staff where applicable, and as members of the Board of Directors. This integration of those with lived experiences into the operations of the organization have been part of its fabric since its foundation. Thus the agency has considerable experience in the benefits, and occasional challenges, that this presents. The other programs have not yet established ways for those with lived experience to be involved in service delivery.

Formalization of policies and procedures.

Each of the programs has both staff and client manuals which detail basic policies and expectations. As fairly recently formed programs, Pathways Edmonton and Homebase operate with many details of operational procedures informally adopted but not articulated in formal documents. Some of this is evident in the struggle that Homebase and the Pathways Edmonton programs have in deciding the number of times and the circumstances under which individuals as re-housed when a placement breaks down, or under what circumstances and with what criteria clients are deemed ready for “graduation” from the program. Another example arises from the programs’ vision of the extent to which support

services are offered by referral or by program staff, such as the extent to which they have intentionally developed additional support activities – socialization, daily living skills and recreation. The operational components at the Alex Pathways are somewhat more formalized while those at Houselink are extensive in detailing expectations for staff and tenant/members.

Landlord-tenant arrangements

There are different landlord-tenant arrangements across the programs, which run across a continuum of client as lease holder to program as leaseholder. Homebase acts solely as a negotiator in establishing the rental agreement, and has the client as signator and holder on the lease. Both Pathways programs have had a mixed model of being the lease holder in some instances and having the client as lease holder in others. Houselink is the landlord and lease holder for all its tenant/members and has a tenant agreement with each person housed. As landlord, it is subject to the tenancy act in Ontario.

The Alex Pathways acts as a landlord in many instances, namely that it holds the lease and acts as the legal intermediary between the tenant and the property owner/manager. However, program documents and information provided to clients does not extend to the level of specificity of how housing responsibilities and disputes are handled. Neither Homebase or the Pathways Edmonton programs take on landlord responsibilities. Instead staff negotiate individual lease agreements with landlords on a case-by-case basis and intervene when there are issues with the housing arrangement and landlord/tenant disputes.

The issue of whether to act only as a negotiator or to take on responsibilities as lease holder has been an issue of considerable struggle for the Pathways programs. Issues of landlord/client relationships are impacted when the program both provides support services and acts in a legal capacity in a person's tenancy. However, control of a specific rental unit allows program staff to place another person in a unit when a placement fails, without the struggle of having to find a new suitable, affordable unit in a very tight housing market.

The Pathways programs, having some experience in both models, have considerable experience and practice wisdom in this regard.

Houselink, as landlord for all tenants, has a clear set of documents that articulate expectations of tenant members in their responsibilities as tenants of the agency. It provides a handbook that details the agency's responsibilities as a landlord, the situations that may require attention by the agency/landlord and the attendant responsibilities that tenants have. Policies articulate instances where there are disputes between the landlord and a tenant and the course of action and appeals processes that are available.

Although Houselink owns a substantial number of its housing units, approximately one third of its units are leased from private landlords or through arrangement with social housing providers. In all cases the agency assume the leaseholder responsibilities and thus all tenant issues are handled in a uniform manner. In addition to tension between being a landlord and support provider in one, Houselink identifies benefits that promote housing retention. That is, when a support or case management relationship has been terminated for any reason, and the person's housing is at risk, Houselink's support workers intervene as agents of the landlord with clear warning letters that outline consequences under the RTA (Residential Tenancies Act) while employing eviction prevention strategies incl. conflict resolution with other tenants, supports around rental arrears, addressing behaviour disturbing other tenants of their reasonable enjoyment, referrals to additional medical and non- medical supports and services including reconnecting with case management. In this regard, support and landlord functions are fully integrated together.

Program admission practices and procedures

Housing first programs are expected to house new applicants as quickly as possible and not to maintain a waiting list of homeless persons. In reality, all programs in this study have limited resources to deal with the excess of applicants requesting housing. The intake and

waiting lists are handled differently in the four locations which extend to three cities with evolving intake and placement processes.

All of the programs had direct referral and admission practices until 2009. Since then three of them have become part of a system-wide effort to centralize housing referrals into supportive housing programs. In Toronto, a centralized intake process for those with mental illnesses and addiction problems who require supportive housing, handles referrals for 29 participating organizations that specialize in supportive housing for this sector, including Houselink. Applicants are referred to agencies on a rotating basis, but if an individual specifies a specific program, he/she will be referred to that program when a space becomes available.

In Calgary, both Homebase and The Alex Pathways programs are part of a centralized process that was developed with assistance from the Calgary Homeless Foundation. In each of these instances, a paper-based intake process screens participants for eligibility and refers them to the appropriate agency, based on the presence of mental health, addictions, co-occurring disorders mental health, addictions or physical health disorders. In Toronto, the waiting list is maintained by the centralized intake group (CASH) and referrals are only made to an agency when a housing vacancy occurs. In Calgary, each program/agency keeps its own waiting list, which is dependent on the number of supportive housing units it is allocated, and the set capacity of each assertive community treatment (ACT) or intensive case management team (ICM) at Pathways and Homebase respectively. Pathways Edmonton maintains its own wait list from those referred by a variety of agencies serving those who are homeless and have mental illnesses and co-occurring addictions problems.

Organizational leadership

Leadership in each program has varied in professional background and thus organizational vision for the program. Pathways Calgary began under the auspices of a physician with no prior mental health services experience. It has subsequently been assigned to a psychologist with considerable mental health and community experience who has provided

a holistic guiding vision to program development and stability, both for clients and staff. Pathways Edmonton was developed and led for its first four years by a social worker with substantial mental health experience.

Homebase way similarly led through its initial development by a social worker and is currently under the management of a social worker. Houselink was developed by a group of concerned citizens to address impacts of deinstitutionalization and continued with an emphasis on community development, empowerment, and choice.

All four organizations have undergone leadership changes in the last four years, with each losing its director (ED). The Program director in Edmonton has been replaced by a person who is an attorney by profession. The Pathways Calgary has a person with a Masters' degree in psychology as program director. Homebase is headed by a program manager and both it and Houselink have social workers as program heads. Houselink continues to be led by an executive director with a Masters' degree in social work.

At the Alex Pathways the person holding this leadership position (program director) changed twice within a year. The program leadership instability was addressed by the appointment as program director of a senior staff who had been with the program since its inception. This person has retained the organizational mission and *housing first* practices, carefully building a strong, integrated team. Enhanced funding for the Pathways program has also had an impact on staff. Salaries for front-line staff are higher than in other programs, and there are generous educational and enrichment opportunities for staff. This in turn has resulted in increased staffing stability.

In contrast, although Homebase serves as many clients as the Alex Pathways (about 200 each), the Pathways program has a director and Homebase a program manager, which connote different levels of responsibility and authority. While Pathways is able to provide many services in house, with a resulting enriched staff, Homebase staff need to expend additional time and resources to access community-based serves, increasing their perceived work load. These factors, along with salary inequities between the two programs, create

intra-organizational tensions and promotes Pathways as the senior program. Homebase as staff perceive the inequities negatively and this contributes to a lack of positive organizational climate.

Organizational stability has also been strengthened at Houselink where the retirement of the long-serving ED and her replacement was able to both expand some programs and support services while also increasing organizational capacity n its electronic capturing of salient tenant/member data. This has resulted in the organization's increased ability to report on housing activities and outcomes in ways that allow comparison with other programs.

The founding program director at Pathways Edmonton left for an out-of province position and was replaced by a person who had a legal background as an attorney but no clinical or social services delivery background prior to assuming this position. The learning curve required to meet the challenges of vulnerable persons with complex problems has been quite steep and it is premature to assess how this change will impact the operations of the program. At about the same time, the program director of Homebase was replaced by a clinician, but one who had recently moved to the West and thus has needed an opportunity to acclimate to the Calgary environment. This director has also been challenged by the large staff turn-over the happened shortly before her arrival, and the resultant need to re-build the ICM teams in the program. Again, it is premature to assess what impact this change will have on organizational functioning or client outcomes.

The impact of organizational and leadership changes on client experiences, satisfaction and housing stability are not necessarily felt immediately and may not be reflected in the annual reports of these programs for another year. What will be important is to determine if they remain faithful to *housing first* principles and practices as these leaders settle into their roles, and then to note any correlations between organizational changes and program outcomes.

Staffing

All programs have a range of disciplines represented in their staffing models. Most prevalent are social workers, rehabilitation, recreational/occupational therapy and general mental health workers with a human services background. The Pathways programs supplement their staffing with physicians, including psychiatrists (part-time) and nurses, in their medical clinics. Staff are sectioned into teams. In the two Pathways programs these are considered ACT teams as they include the medical and psychiatric services available in the program. At Homebase the teams operate under an Intensive Case Management (ICM) model, providing a high level of support to a limited number of clients. However, the team does not actively share client responsibilities among themselves. Houselink views its support staff as member support workers who perform generalist case management[11] responsibilities and is thus considered to be a general case management arrangement. However, Houselink assigns worker and team client load according to the level of member need with some housing units identified as in need of higher levels of contact and support.

In all programs, the teams meet together to discuss and plan for daily and weekly activities and priorities with housing, rehousing and emergency client needs. However, the extent to which teams share clients, with all team members able to step into a given situation, varies among programs. ACT teams are expected to share all client responsibilities, although each client has a primary contact. Homebase clients are assigned primary support workers, but do not share client responsibilities except in an emergency or absence of the worker. Like Homebase, Houselink supportive housing workers have primary responsibility and have the assignment of backup workers to assist each other with emergencies, worker absences and extenuating circumstances. The main difference between Homebase and Houselink in the aspect of program function appears to be the degree of intentional daily sharing and cooperation rather than formal designation of mutual work. That is, Houselink staff are more likely to work together on client needs on an ongoing basis.

[11] Case management is used here as a general term to connote those activities of assessment and service linkage that assure client needs are identified and actively addressed.

Support Services

All programs use a case management approach to client supports. A comprehensive assessment at intake identifies areas in which a new client/tenant member will require support and referral to additional programs and entitlements. Clients determine which needs they will address and what the priority of these action will be. A client support worker, variously called a case manager or support worker, or client care coordinator, is assigned each client. These workers are divided into teams, with each team having on an average of 6 to 10 workers and 70 to 100 clients per team (depending on the program). The number of clients per worker ranges from 12 to 20 depending on acuity of client need for services and degree of client stability in their housing.

In some programs, such as Homebase and Pathways Edmonton, the support worker is responsible for locating and arranging for housing. Houselink has a housing tenancy unit that handles tenancies in its own and its leased housing units. It also has an eviction prevention program to address those situations where a tenant/member as at risk of housing loss. Both Pathways and Houselink programs are moving towards having designated housing coordinators who locate and negotiate leases with landlords.

Program activities

The programs offer a variety of support services and recreational activities, either directly or through arrangements with local organizations. They differ in the extent to which these activities are offered directly by program staff or elsewhere in the community. The two Pathways programs have medical and psychiatric services available at program offices while Homebase and Houselink refer clients to community-based services. Houselink has been able to establish formal agreements with mental health service providers so that clients can receive targeted services if needed to address health and wellness: such as harm reduction, smoking cessation, psychiatric support, physical medical support, dental,

physical exercise etc.. It also provides a range of activities focused on developing healthy communities and housing retention– supported employment (enhances sense of ownership in HL, skills and income) food program (which enhance skills, encourage social networks and friendships) social recreation (which enhances skills, friendships, social networks, and connections to the larger community).

Homebase relies on a referral process to access services found in the local community but finds this arrangement to be filled with the obstacles that long wait lists for specialized psychiatric services entail. The same difficulties arise in accessing medical services beyond emergency clinics. Homebase clients do not have preferred access to the Alex medical clinics and must meet these clinic's eligibility requirements. Most local physicians are not accepting new patients and of the few who do, there is a reluctance to take on patients who have the complex needs (Hwang, 2001) and dubious record of treatment compliance that haunts many who have lived on the streets. Thus, clients' medical needs are often not able to be met expeditiously. This is a significant issue for many clients who have been homeless for extended periods of time, and who have numerous unmet medical needs.

Beyond medical services, the programs offer social, recreational and independent living skills activities. The Alex Pathways offers a number of different program activities at program offices, cooking and nutrition, money management, some pre-vocational groups, sobriety and substance use groups and social events. All are freely available to all clients but no client is required to access any activity. The Pathways Edmonton has a few program offerings related to household maintenance such as cooking and shopping on an occasional basis, an exercise, walking and swimming activities and also offers a substance use/sobriety group. Other activities are primarily through linkage with local organizations. Houselink provides a range of activities and groups extending from skills of daily living, cooking/nutrition, to writing, and social/recreational, all at program offices and out in the community. Some of these activities are peer-led. One activity, the DREM survey, was a peer-led initiative to learn about member experiences of both recovery and Houselink's

recovery-oriented services[12]and has developed into a Houselink supported recovery advocacy initiative. A separate activity is the Dream Team, a supportive housing network initiative that engaged residents of supportive housing to advocate for more supportive housing. It requested to be housed at Houselink because of its commitment to consumer led initiatives.

Cultural and Ethnic Components

All four program have a blend of ethnically diverse clients/members. While the majority are Canadian born, and self-reported Caucasian ethnically, a distinct group are Aboriginal or immigrant. In Calgary and Edmonton, there is a significant component who report Aboriginal or Metis Status while in Toronto, the diversity reflects the higher immigrant and refugee population of the city. Most programming does not take ethnic and cultural diversity issues into inclusion, with two exceptions. Pathways Calgary has developed some specific Aboriginal activities including healing circles and an annual pow-wow. Houselink strongly supports Toronto Gay Pride activities as well as activities involving people with mental illness and addictions including Mad Pride, and the Psychosis Symposium. Beyond this, there is little reflection of diversity issues in the programs.

Client retention rates

One of the major assertions by *housing first* programs is their ability to have clients remain in long-term (stable) housing provide stability for this vulnerable population (Padgett, Gulcur, & Tsemberis, 2006; Tsemberis & Asmussen, 1999) . This includes people who have their own apartment, room in a house, supportive housing program, boarding house, group home or long-term arrangements with family and friends. The At Home/Chez Soi study used similar outcome criteria in determining if participants were stably housed, and provided additional detail as to the percent of participants who were stably housed all of

[12] DREEM is a recovery-oriented survey developed by Ridgway and colleagues (Ridgeway & Press, 2004)

the time (66%). Some of the time (22%) and not at all (16%) (Goering et al., 2014). Because all participants in the Pathways and At Home/Chez Soi studies were tracked for the duration of the study, drop-outs were presumed to have lost housing and be homeless. These studies did not indicate housing retention for those who leave the program thus creating the assumption that program delivery supportive housing is the benchmark for housing stability.

In this report, we examined outcomes in programs that report on clients who remain in the program and remain housed by the program. No provision is made to determine if any people who leave the program also remain stably housed. However, we received reports that some residents move on to other accommodation of their choosing, and these successful moves should be reflected in program success. In order to differentiate these outcomes we report separately on program retention and continued housing stability.

Discharge and retention rates

The first and foremost promise of *housing first* programs is that ending homelessness involves having those housed remain in their housing (Stefancic & Tsemberis, 2007; Tsemberis, 1999) . While positive outcomes in other areas of functioning are often reported, it is important to note that the prime focus of this approach is intended to be to keep people in stable housing. Thus housing retention is the first and foremost hallmark of program success. In instances where the alternative to remaining housed through program auspices is absolute homelessness, program retention rates are critical. However, where clients stabilize their lives and move onto other forms of stable housing, retention rates in a specific program are less important that longer term residential stability. This allows for programs to "graduate" those who move on to other life styles in their recovery. With this important factor in consideration, we examine retention rates along two different criteria: those housed within the program and those who continued to be in stable housing but moved on from the program auspices.

Programs using a *housing first* model report retention rates ranging from 78% to 86% of total admissions (Waegemakers Schiff & Rook, 2012), while the recently released final At Home Chez Soi study reports on those housed continuously (62%) and part of the time (22%). The methodology used for calculating these rates makes it challenging to compare outcomes with the programs in this report that did not provide data on this difference. The three programs that are focused on housing regardless of who is the landlord (the two Pathways programs and Houselink), provided reports on client retention but not on the total amount of time spent housed versus unhoused but still considered a program client. Homebase provided some reports on clients housed but not on the cumulative time spent housed or partially housed.

Another issue arises because some programs report on clients who have moved out, but do not necessarily indicate if the move was for positive reasons to other stable housing, such as an individual moving in with family or a partner or to a different more preferred location, or if the discharge was for failure to avoid repeated evictions, remain connected with case management support, etc. Programs also report that some clients have died, and this fact, when included with total discharges, distorts program housing success rates as it is neither a positive nor negative discharge and technically should be excluded from the total count. Since these programs vary in size both in total admission (105 in Edmonton, 188 in The Alex Pathways and 486 at Houselink), and numbers of discharges, small differences represent a greater proportion (percentage) of the total in these smaller programs.

Another confounding issue exists with the Homebase client data. Because Homebase will only discharge a client who refuses further service, those who are repeatedly evicted from housing and require relocation are considered part of the group who remain in the program and are reflected in the reported retention rate of 92%.. Recent program reports indicated at in April/May 2014, 27 Homebase clients were unhoused, which represents 18% of the active caseload. If this figure were to be factored in with a reported 92% retention rate, the actual housing stability becomes 70%, which is still very impressive for a hard to house client group.

In order to recognize difference in retention rates, we examined both the number (and percent) of clients who remain in the program, those who have left for any reason, and then extract those who have left for a positive move to other and those who have died. This leaves people who have left the program because they were evicted or chose not to continue with program support. The true retention rate is presented as those who continue to retain any form of stable housing, whether it is within the program or elsewhere. Program admission and discharge criteria from each program, plus numbers of those leaving for explained and planned reasons and those who passed away, were used in these calculations. The recent retention rates reported by the four programs in this report range as follows:

Housing Retention Compared With the AT Home/Chez Soi Project

	Retention rate including all program exits	**Unplanned discharges – excluding deaths, incarcerations, planned positive moves, move to Addictions treatment; program retention but unhoused**	**Housing retention rate**
Pathways to Housing Edmonton[13]	72% retention.	21.7%	78.3%
The Alex Pathways[14]	68% retention	22.9%	77.1%
Houselink[15]	88.5%	4% to 6.7%	93.3% to 96%
Homebase[16]	92%	18%	70%

[13] 5-year rate
[14] reported rate since program inception in 2009.
[15] represents year-by-year tracking with a significant drop over time.
[16] HomeBase has had a policy of repeated re-housing when a housing arrangement does not work out. Thus in 2012, 95 persons were re-housed a total of 137 times. This practice skews housing retention outcomes.

The Pathways programs report on those who are stably housed all of the time and represent data over three years of operation. Houselink data represents the past five year averages and includes all who are stably housed. The programs do not report on those housed for part of the time or intermittently housed. In comparison, the At hHome/Chez Soi study reported on the percentage of people housed all of the time, some of the time and none of the time. This makes comparison with the national study difficult as retention of permanent housing is not reported in the same way.

Data used to capture residential stability

Homebase	Houselink	Pathways Calgary	Pathways Edmonton	At Home/Chez Soi
No. of days (% of time) in stable housing AND % remaining in program (with or without housing)	Resident member (all are housed); planned moves and evictions	% housing retention – those in stable housing	% of time in stable housing	% of time in stable housing % of time temporarily housed
82.5 % housed at least part of the time 92% remain as clients	94.5 % (5 yr. average)	78 %	77 %	66 %

The rates for those housed permanently are higher for all of the programs in this study than the rate of 66% reported in the At Home project. In part this may be due to the fact that the programs were undergoing initial organization while attempting to achieve housing rates reported by programs with greater longevity (such as the A Pathways New York program which has been in existence for at least 8 years prior to reporting strong outcomes). Houselink, on the other hand, has the strongest and longest documented retention rate of the four programs, and far exceeds that reported in other "housing first" programs. It retains 88.5 % of its member-tenants in housing and this rate rises to between 93% and 96% when planned exits for alternative housing and client deaths are factored into the calculations. These rates are also consistent over the last five years. One lesson from these results is that programs may need to achieve a certain level of operational and staffing maturity in order to achieve best results in housing retention for clients. The Pathways programs in this study had this stability longer than the At Home/Chez Soi programs. They were also components of long-established organizations. This long-term organizational stabiulity is also a factor in Houselink operations. This need for organizational development is a factor that has not been taken into account in the existing reports of housing first programs.

One final item regarding factors that influence retention rates concerns the issue of a "Hawthorne effect", that is the extent to which outcomes are influence be participants behavior because they know that they are part of a research study. As none of the programs in this report was part of an outcomes study, the retention rates in housing cannot be attributed to this influence. Thus we can be fairly certain that all programs have strong positive outcomes that exceed those reported in the literature. At this juncture, there is no way to accurately explain the reasons for this finding since we do not have access to the program details that would enrich understanding of service delivery in the New York Pathways and Canadian At Home Chez Soi projects.

Summary:

There are several ways to summarize the information gleaned from this analysis: to what extent are these programs following a "*housing first"* approach; to what extent do they differ in program policies and procedures; to what extent do they include a peer component, and does this influence program services delivery; are these differences reflected in housing stability either in or outside of the program?

To what extent are these programs "*housing first"* in program organization and service delivery or "housing first" as in keeping with standards promulgated by Pathways to Housing (Tsemberis, 2011)? Appendix A outlines the criteria used to evaluate the Pathways programs for adherence to the model. These criteria were used by Pathways (NYC) staff to assess both the Calgary Alex and Edmonton Pathways programs and both were reported to be in high compliance with these criteria.

While Homebase uses a *housing first* philosophy, it does not employ an ACT team, but instead uses an ICM team (as did some of the At Home/Chez Soi study sites). Original Pathways Housing First program guidelines called for the use of ACT teams to deliver off-site (not connected to housing) services. Current guidelines do not require ACT teams but do emphasize the need for specific approaches that use motivational interviewing to encourage clients to deal with personal and interpersonal problems, including addictions. Homebase follows most of these guidelines, although its reliance on medical and psychiatric services in the community is impacted by the service delivery process in the single-system form of health care in Alberta. As the guidelines regarding formal service agreements for medical and psychiatric services was formulated in an American health care system, these requirements are not as easily applied in a Canadian and Alberta setting.

Some of the Pathways guidelines are most applicable to clients with serious mental illnesses and addictions and do not lend themselves as easily to those who have functional difficulties but not necessarily a major psychiatric disorder. Thus linkage with inpatient treatment programs is not part of the Homebase mandate or service system. Likewise, it

does not have provision for emergency and 24-hour support availability. Provision of ancillary services is also not part of the Homebase program model, as its focus is on housing and supports to maintain housing. Homebase does, however, have a strong commitment to re-house when there is a housing failure. As its annual report attests, this commitment needs review as some persons have been re-housed numerous times, repeatedly failing to take responsibility for appropriate tenant activities and their evictions have taken valuable resources away from opportunities to house additional people.

The policies and operational principles and practices at Houselink also follow those of Pathways, although this may be a misrepresentation as the program has been in existence much longer than Pathways. The main way in which the programs diverge is in the types of housing units available. The Pathways model advocates a scatter-site individual apartment model of housing. This fits well with a New York City housing model where that is the norm. It also fits with a relatively young agency that has to rely on rental agreements to access housing. Houselink's long existence has allowed it to acquire most of its own housing stock and this it has a mix of agency-owned and lease arranged housing units. It offers a variety of housing units, both scatter-site, some in buildings that have a number of rent-subsidized units and in homes where tenants share kitchens and common living areas. This is a housing model found elsewhere in Toronto and not unique to the mental health consumer community. While congregate living is not as popular as individual units, it has appeal for some and thus Houselink can be described as offering a variety of housing units rather than a single model.

Two most important ways that Houselink differs is in its strong commitment to integrating members into its organizational functioning in substantive and not merely token ways and its espousal of a recovery orientation together with the emphasis on developing intentional communities. This recovery philosophy is articulated in formal policy and implemented through numerous activities designed to enhance the functioning and lives of members, including both member and staff training in recovery, using a recovery lens strength-based approach to apply funder required assessment tools and is exemplified though its DREEM study of recovery practices (Houselink Community Homes, http://new.houselink.on.ca/wp-

content/, & 2011, 2010). It can be seen as a holistic and integrated model of housing for mental health consumers. While the other programs may espouse a recovery orientation, there are no specific or discrete activities or documentation that demonstrates how this is put into practice.

The most substantial indication of program effectiveness is tenant/client retention. In that regard, Houselink outperforms all of the other programs and the At Home/Chez Soi programs. It has a long-standing history of retention that is not influenced a "Hawthorne effect" of positive results emanating from those in a research study or from a temporary shift in housing availability or staff practices. Thus it presents a model of inclusion and recovery that exceeds other housing approaches for persons with mental illnesses and addictions.

Client Characteristics: A comparison Across Programs

An additional aim was to correlate client characteristics across programs accessed and to compare these characteristics with those housed in the process of the At Home/Chez Soi study conducted by the Mental Health Commission of Canada (MHCC). The following presents the results of data collection and analysis across programs and a comparison with the MHCC At Home/Chez Soi study.

In contrast to the At Home/Chez Soi study, all of the present programs have been in existence for at least 5 years (Houselink has been in operation for over 37 years) and thus have moved beyond the implementation to full scale operation. We examined the results of a sub-set of assessment tools used by the MHCC At Home/Chez Soi study in order to understand and compare participant characteristics, including mental health, addiction and housing experiences in each program. This allowed us to examine the anecdotal reports that each program addresses needs of different sub-groups of this high risk (for homelessness) population.

Prior to the onset of this study, senior research staff from At Home/Chez Soi assisted the two Pathways programs in selecting a subset of the data instruments used by the At Home/Chez Soi study, which could be administered with minimal resources. The MHCC staff were available for consultation but were not involved in program implementation, operations, data collection, or analysis. Homebase elected to also complete some of these instruments. Data entry and analysis were left pending the opportunity to access external support. The funding from the present study allowed this opportunity to enter data electronically, analyze and compare across programs. The fourth program, Houselink, which had a strong housing first philosophy, was enlisted as a comparison program for purposes of this study. It selected a similar sub-set of the instruments used in the At Home/Chez Soi study as part of their participation in this project. The four programs each selected data collection instruments in common with At Home/Chez Soi, but did not collect all of the same instruments. Comparisons on similarly collected data are provided in this report.

Data Collection protocols

In the At Home/Chez Soi study, data was collected by research assistants and participants were p[aid a nominal stipend for their time at each data collection point. In contrast, data collection in the two Pathways programs and Homebase was the responsibility of case managers and direct service staff, and was administered in the course of their regular clinical responsibilities. All participants were provided with informed consent and were given the opportunity to participate. Ethics approval for use of this data was obtained by the University of Calgary Conjoint Faculties Ethics Review Board.

Case managers administered the questionnaires to current clients or participants. Incentives were not available for participants. For the three Alberta programs, questionnaires were administered at baseline, 6 months, 12 months, 18 months, and 24 months following

enrollment in the program[17], but only baseline data was intended for, and analyzed for, this study. Houselink collected baseline data for a sub-set of its client population. This program assigned a staff to coordinate data collection. Peers were trained in data collection and staff supervised for completeness of the data sets. In the case of Houselink most of this data was collected retrospectively (to program entry date), as was some data from clients in the Alberta-based programs. Comparisons of baseline across sites and repeated measures over time may be impacted by this retrospective data collection.

Data overview

Quality and completeness of data varied across programs and across variables. Data completeness was the biggest concern as large numbers of missing data make it difficult to determine if the figures are representative of the entire sample. In some cases, it was also difficult to know if a participant did not answer a question or if missing values indicated a negative response. The quality of data entered was generally good, although there were some instances of mixed numerical and text entries within the same variable. One area of concern is that some programs collected data retrospectively, but did not provide an indication of when, in the process of securing or establishing housing, the retrospective data collection occurred for a specific participant. This makes it difficult to truly compare baseline information across programs, or to look at progress over time because baseline does not necessarily indicate the point of entry into the program. However, the data does provide an overview of clients served across all programs.

All percentages reported reflect valid, non-missing data. For example, if 40 of the 50 participants answered the question on age, the percentages are calculated with a denominator of 40.

Overview of participants from all programs

[17] Although programs attempted to collect data every six months, in reality this was less systematic than planned and thus data sets for subsequent time intervals are incomplete.

The range of participants was from 50 for Homebase to 74 for both Pathways programs and 74 for Houselink. By program requirements, all Pathways and Houselink participants had a history of a mental illness and a diagnosis of a major mental illness. A lifetime history of substance abuse was reported by the majority of participants from all programs and ranged from 83% to 95%.

Their ages ranged from 21 to over 67, with most reported as middle-aged (35 to 54). All reported extensive periods of homelessness, ranging from less than a month to over 360 months. This range accords with At Home/Chez Soi participants who had a range of homelessness extending from zero to 384 months. The longest average homeless stay was in Edmonton. Homebase and Houselink had an average homeless range that was near that of the MHCC national study.

Homebase

Homebase began operations in 2009 but only began to collect data systematically on clients in 2011. Although Homebase has over 158 housed clients, the program was able to provide relatively complete data sets on 50 participants. Of these participants, 78% were male, and the average age was 42 (youngest 20 and oldest 71). All participants were born in Canada, and 30% identified as Aboriginal while 11% reported other ethnocultural status. A small number, 2%, reported prior military service for Canada or an ally.

The majority of participants (96%) were single, while 4% were married or in a common-law relationship. Information on the number of participants who are parents was not consistently collected. Twenty-three per cent of participants reported being in foster care at some point during their own childhood.

Twelve per cent of participants completed high school, while 76% had less than a high school education and 12% attended or completed post-secondary education or training. The majority of participants did not report on current employment status, desire to have a job, or reasons they were not working. Program data from 2012 indicates that 54% of clients

report some form of earned income, but most of this is from casual employment and often from activities such as bottle picking. At program entry, forty-five per cent reported no income, while 11% earned income from work, 30% received income from government sources, and 6% received income from a pension. The remaining 8% cited other sources, such as pan-handling, for their income.

On program admission, participants reported that they came to the program from various locations: shelters (41%); institutions such as a hospital or treatment facility (26%); staying with friends of family (19%); transitional housing (7%); and other unspecified housing situations prior to program entry (7%).

Ninety-two per cent of participants reported that they were chronically homeless at entry into the Homebase program. Of these participants, 14% had been homeless for one year, while 86% had been homeless for two years or more. On average, participants reported that their longest lifetime period of homelessness was 34 months. Homebase did not collect information on ability to live independently in the past or on participant's current living situation.

Seventy per cent of participants reported some involvement with the police or justice system within the last 12 months. Of these, 70% had interactions with police and 25% had court appearances in the last year.

Sixty per cent of Homebase participants completed information on the baseline co-morbid conditions questionnaire. Of these participants, they had an average of 5.2 co-morbid physical health conditions at baseline. Common conditions included hepatitis C (28%), heart disease (24%), and asthma (23%). Sixty per cent of participants reported a past traumatic brain injury or head injury.

Eighteen participants also answered questions about their co-morbid conditions at baseline and 12 months. The average number of conditions decreased slightly (4.4 versus 4.0) but the difference was not significant.

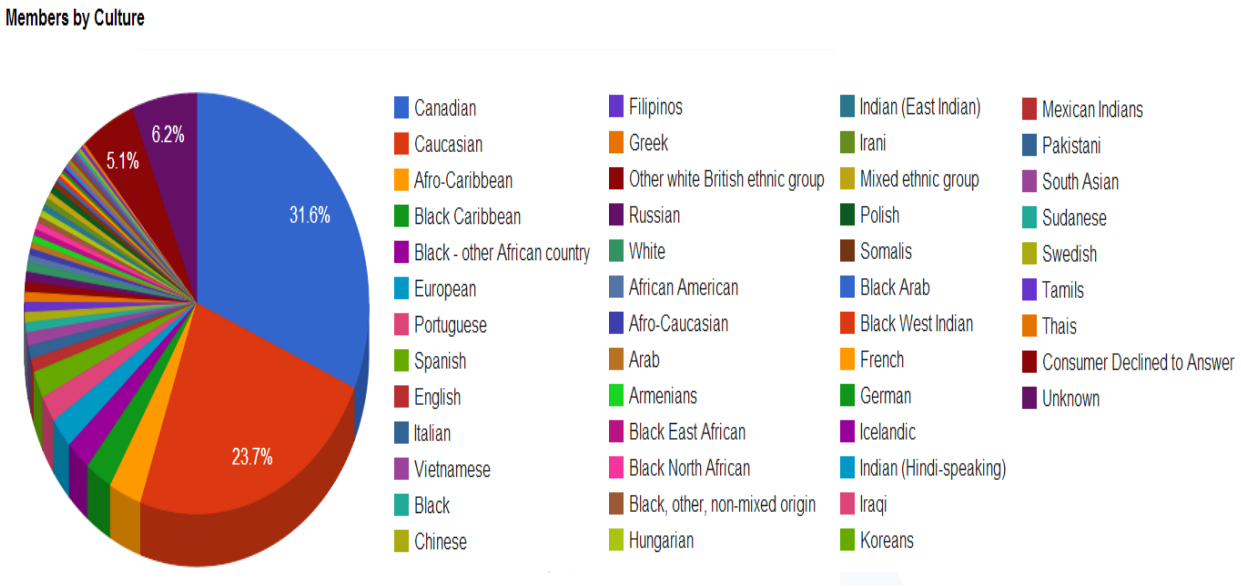
Twenty-eight participants completed a questionnaire on quality of life, the QOL-20, at baseline. This questionnaire asks about five domains of quality of life, and also provides a global summary score for overall quality of life. Scores can range between 20 and 140, with higher scores indicating a better quality of life. At baseline, participants reported an average QOL score of 82.3 (43-127, sd 23.4). The sum score was also strongly positively correlated with the global measure of quality of life ($r = .693$, $p < .001$).

The GAIN is a questionnaire on substance use. Each GAIN questionnaire contains five questions about substance use that are used to determine if the participant has a history of a substance use disorder in the past month, in the past year, and over their lifetime. Within each time period, a higher score indicates more affirmative answers to substance use disorder symptoms. Twenty-six participants completed the GAIN, at baseline. Of these, 69% reported a history of substance use disorder in the past month, 88% reported a history of substance use disorder in the past year, and 92% reported a lifetime history of substance use disorder. The mean number of symptoms for the past month, past year, and lifetime were 1.8, 3.1, and 3.9, respectively.

Summary: Homebase clients can be described as primarily single men who have a minimal amount of formal education and who have been homeless for an extended period of time. **A** significantly higher proportion of members have an aboriginal background as compared to the general population and to the homeless population in Calgary. They have a pervasive history of recent (past month and past year) of substance abuse and they are unlikely to have formal interpersonal relationships (marriage or common law) or to be parents. They often have chronic health conditions and report a high rate of traumatic head injury. They are quite likely to have has involvement with the justice system in the last year (as perpetrator as opposed to victim of criminal activity)**.**

Houselink

Houselink collected data on 74 participants. Of these participants, 53% were male and 47% were female, which is a higher percentage of female participants than is typical. The average age was 50 (youngest 21 and oldest 68). Seventy per cent of participants were born in Canada, and 5% reported Aboriginal status and 35% reported other ethnocultural status. None of the participants reported prior military service for Canada or an ally. The following chart, and a similar one for Pathways Edmonton clients on p.85 present graphic depictions of the programs, client ethnic and cultural diversity. These are intended to illustrate this diversity and not to analyze its implications.



The majority of participants reported they were single (80%), and 16% reported having children.

One per cent of participants reported high school as their highest level of education, while 47% had less than a high school education and 52% attended or completed post-secondary education or training. Thirty-four per cent reported that they were currently unemployed, which is a much lower percentage than any other program reviewed in this analysis.

Participants were engaged in a variety of employment types, including 56% in a special work program, 33% in full-time, part-time, or casual work, and 11% self-employed. Of those who were unemployed, 36% cited both physical and mental illnesses, 34% cited mental illness, 18% cited physical illness, and 11% cited other reasons[18] why they were not working. Of those not working, 82% stated that they would like to have a paid job in the community. Income sources included: government programs (70%), employment earnings (23%), or pension (7%). Most participants (44%) earned an annual income of $10,000-$14,999, with 28% earning less and 28% earning more.

An insufficient number of participants answered questions on chronic homelessness for that information to be included in this analysis. On average, participants reported that their longest lifetime period of homelessness was 30 months. Houselink did not collect information on primary residence prior to entry in program, ability to live independently in the past, or on participant involvement with the justice system.

On average, participants reported 4.85 (range 0-16) co-morbid physical health conditions at baseline. However, only about half of the Houselink participants completed information on co-morbid conditions so these figures not be representative of the entire sample. Common conditions include diabetes (30%), asthma (26%), and cancer (16%). Thirty-six per cent of participants reported a past traumatic brain injury or head injury. Houselink did not collect information on co-morbid conditions at 12 or 24 months.

All participants completed a questionnaire on quality of life, the QOL-20, at baseline. This questionnaire asks about five domains of quality of life, and also provides a global summary score for overall quality of life. Scores can range between 20 and 140, with higher scores indicating a better quality of life. At baseline, participants reported an average QOL score of 88.8 (22-136, sd 26.8). The sum score was also moderately positively correlated with the global measure of quality of life ($r= .590$, $p<.001$).

[18] Other reasons included not able to find work, not a good fit, lack of work experience, learning problems, stress and unfair issues.

Seventy participants completed a questionnaire on substance use, the GAIN, at baseline. Each GAIN questionnaire contains five questions about substance use that are used to determine if the participant has a history of a substance use disorder in the past month, in the past year, and over their lifetime. Within each time period, a higher score indicates more affirmative answers to substance use disorder symptoms. Of these, 50% reported a history of substance use disorder in the past month, 63% reported a history of substance use disorder in the past year, and 83% reported a lifetime history of substance use disorder. The mean number of symptoms for the past month, past year, and lifetime were 1.0, 1.6, and 2.9, respectively.

Pathways Calgary

Pathways Calgary provided data sets on 75 participants. Of these participants, 77% were male, and the average age was 45 (youngest 23 and oldest 73). The majority of participants (81%) were born in Canada, with 13% reporting Aboriginal ethnicity and 16% reporting other ethnocultural status. The majority of participants were single, never married (68%), and 31% reported having children.

Thirty-seven per cent of participants reported being in foster care at some point during their own childhood. Nineteen per cent of participants completed high school, while 67% had less than a high school education and 14% attended or completed post-secondary education or training. Seventy-nine per cent reported that they were currently unemployed. None of the participants reported prior military service for Canada or an ally.

Eighty-three per cent of participants cited mental illness as the reason they were currently not working, and the remaining participants cited physical illness or a combination of both physical and mental illnesses as the reason they were not working. One participant mentioned the lack of a driver's license as a barrier to gaining employment. Despite the high number of unemployed participants, 64% reported they would like to have a job in the

community. The most common source of income was from government assistance (disability/AISH/welfare/income assistance). The majority (84%) of participants had an annual income of $15,000-$19,999[19], with 3% earning less and 13% earning more.

At program entry, participants reported coming from a shelter (45%), an institution such as a hospital or treatment facility (36%), or staying with friends of family (4%); 15% reported other unspecified housing situations prior to program entry. Ninety-nine per cent of participants reported that they were chronically homeless at entry into the program and 89% of participants reported they spent one or more nights in a shelter in the six months prior to program entry. The program did not collect information on participant's ability to live independently in the past, or length of time homeless in the past.

Ninety-five per cent of participants reported some involvement with the police or justice system within the last 12 months. Specifically, of those who reported involvement, 97% had interactions with police and 97% reported court appearances in the last year.

On average, participants reported 3.71 (range 0-13) co-morbid physical health conditions at baseline. Common conditions include asthma (25%), hepatitis C (18%), and chronic bronchitis or emphysema (13%). Thirty-seven per cent of participants reported a past traumatic brain injury or head injury. Pathways Calgary did not collect information on quality of life.

Sixty-five participants completed a questionnaire on substance use, the GAIN, at baseline. Each GAIN questionnaire contains five questions about substance use that are used to determine if the participant has a history of a substance use disorder in the past month, in the past year, and over their lifetime. Within each time period, a higher score indicates more affirmative answers to substance use disorder symptoms. Of these, 54% reported a history of substance use disorder in the past month, 66% reported a history of substance use disorder in the past year, and 89% reported a lifetime history of substance use disorder.

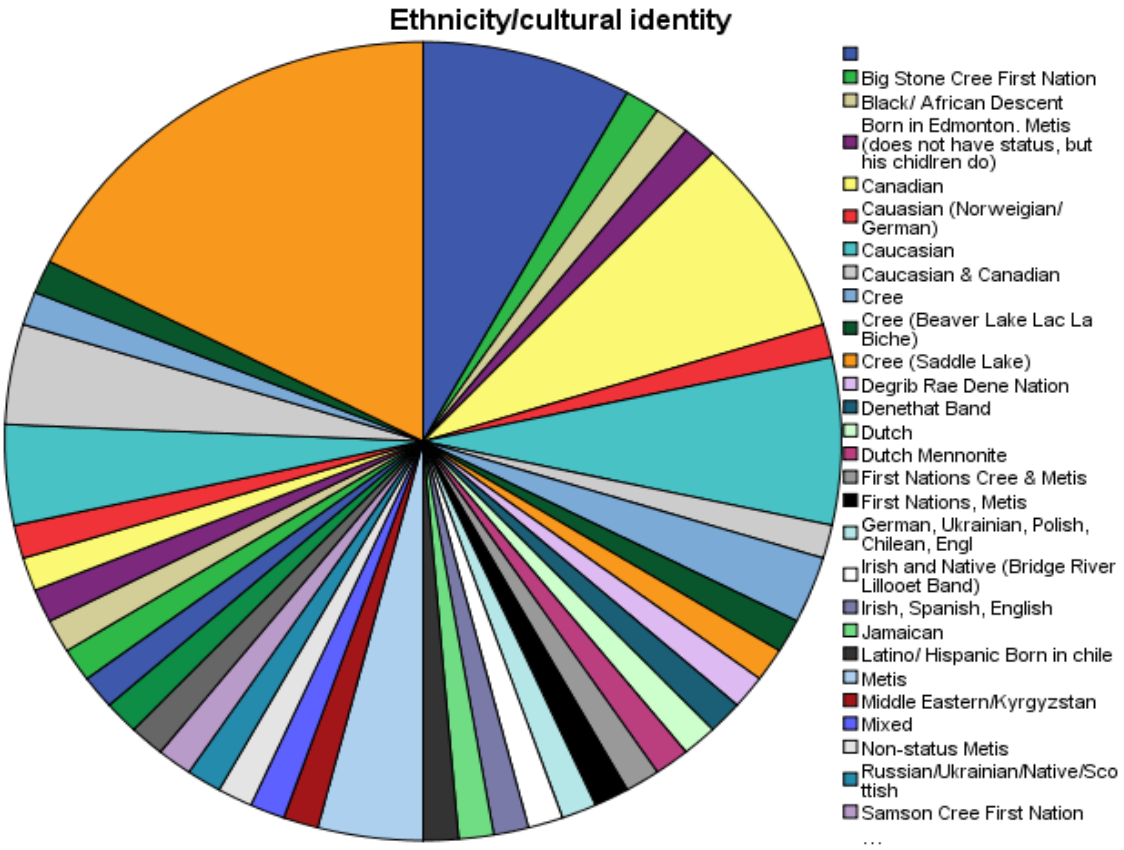
[19] The current AISH monthly payments of $1,588 equate to $19,056 per year. Individuals are allowed to earn up- to $800 monthly additional (employment) income before any deductions occur.

The mean number of symptoms for the past month, past year, and lifetime were 1.1, 2.0, and 3.4, respectively.

Pathways Edmonton

Pathways Edmonton collected data on 75 participants. Of these participants, 52% were male and 48% were female, which is a higher percentage of female participants in a homeless population than is typical. The average age was 43 (youngest 21 and oldest 65). Information on country of birth and ethnocultural status was not collected in a manner consistent with the other programs.

The following graph depicts the ethno-cultural diversity in the Edmonton cohort. Thirty-five per cent of participants reported Aboriginal status.



Sixty-two per cent of participants were single, with 4% married or common-law and 34% widowed, divorced, or separated. Forty-eight per cent of participants reported having children. Of these, 9% currently provide support for their children. Twenty-two per cent of participants reported being in foster care at some point during their own childhood. None of the participants reported prior military service for Canada or an ally.

Pathways Edmonton did not collect information on education. The majority of participants (94%) reported that they were currently unemployed. Of these, 59% cited mental illness as the reason they were not working, while 22% cited physical illness and 19% cited both physical and mental illnesses. Of those not working, 86% reported they would like to have a job in the community. Income sources included: government assistance (51%), pension (40%), and employment income (9%). Most participants (59%) earned an annual income of $10,000-$14,999, with 34% earning less and 7% earning more.

At study entry, common living statuses included couch surfing (25%) and institutions (24%). Fifty-nine per cent reported staying in a shelter at least one night prior to program entry and 70% of participants reported that they were chronically homeless at entry into the Pathways Edmonton program. The average length of homelessness was 66 months. The program did not collect information on ability to live independently in the past. Seventy per cent of participants reported some involvement with the police or justice system within the last 12 months.

On average, participants reported 6.10 (range 2-13) co-morbid physical health conditions at baseline. However, only 28% of the Pathways Edmonton participants completed information on co-morbid conditions so these figures may not be representative of the entire participant group. Common conditions include hepatitis C (52%), asthma (38%), and chronic bronchitis or emphysema (21%). Forty-five per cent of participants reported a past traumatic brain injury or head injury.

Thirty-six participants completed a questionnaire on quality of life, the QOL-20, at baseline. This questionnaire asks about five domains of quality of life, and also provides a

global summary score for overall quality of life. Scores can range between 20 and 140, with higher scores indicating a better quality of life. At baseline, participants reported an average QOL score of 73.4 (29-115, sd 19.3). The sum score was also strongly positively correlated with the global measure of quality of life ($r = .603$, $p < .001$).

Thirty-nine participants completed a questionnaire on substance use, the GAIN, at baseline. Each GAIN questionnaire contains five questions about substance use that are used to determine if the participant has a history of a substance use disorder in the past month, in the past year, and over their lifetime. Within each time period, a higher score indicates more affirmative answers to substance use disorder symptoms. Of these, 51% reported a history of substance use disorder in the past month, 77% reported a history of substance use disorder in the past year, and 95% reported a lifetime history of substance use disorder. The mean number of symptoms for the past month, past year, and lifetime at baseline were 1.2, 2.2, and 3.7, respectively.

Program Comparisons

Housing First models were designed to serve persons with mental illness and co-occurring addictions who are experiencing homelessness. Therefore, there are bound to be commonalities in participant characteristics across programs using a Housing First model. Table 1 describes the baseline participant characteristics by site included in this study (Homebase, Pathways Calgary, Houselink, and Pathways Edmonton) along with baseline participant characteristics of those enrolled in the At Home/Chez Soi study. Table 2

Between sites and At Home/Chez Soi

The majority of participants at each site were middle aged (35-54). However, Homebase participants were more evenly spread across all age groups. Houselink had the smallest number of participants who were 34 or younger (6%) and the highest number of participants 55 or older (38%). Both Pathways programs had similar numbers of persons

in each age category. While the age ranges were similar, only 10% of At Home/Chez Soi participants were over 55, and 33% were 34 or younger. The At Home /Chez Soi cohort was younger than the other Pathways programs, and had the least number of older participants. The oldest average age was among the Houselink participants. This may be a factor of the program's longevity in that some participants have been with the program for upwards of 20 years.

Conclusion: The two Pathways programs had a similar age spread among participants. And this spread more closely mirrors that of the At Home/Chez Soi study than either of the other two programs. There does not appear to be an easily discernable reason for the differences in the other two programs.

Gender

In terms of gender, Homebase and Pathways Calgary had significantly more men than both the At Home/Chez Soi study or the Edmonton and Toronto programs. Houselink and Pathways Edmonton had many more female participants and a gender split that was closer to 50/50 than reported elsewhere and in other studies. The reason for this is unclear and may be coincidental. However, it may also affect other demographic aspects of the participant pool. .

Conclusion: Although the ages reported in Edmonton mirrored the At Home/Chez Soi project, the gender split was quite different. As Houselink and Pathways Edmonton admit those referred, regardless of gender, it is unclear as to the reasons for this relatively even gender representation. However, the experiences of these programs should be followed as the significant female presence may influence other program activities and outcomes.

Ethnicity

Pathways Calgary and Houselink were very similar to At Home/Chez Soi in percentage of participants born in Canada. Only 40% of Homebase participants replied to the question

about being born in Canada, and thus it is unclear as to how many were immigrants or refugees. More complete data comes from other programs, so that 81% of Pathways Calgary and 70% of Houselink participants were born in Canada, very similar to At Home/Chez Soi participants (81%). Pathways Edmonton did not provided information on country of birth.

Conclusions: Given the disparate information available across sites, it is difficult to form and substantive conclusion. As the At Hoe/Chez Soi participants were specifically targeted by ethnicity in Toronto and aboriginal status in Winnipeg, comparison by site would be misleading since none of the four programs in this study had targeted recruitment beyond a major mental health diagnosis.

Aboriginal representation

Aboriginal participants varied greatly across programs: 35% of Pathways Edmonton participants; 30% of Homebase participants; 13% of Pathways Calgary participants; and 5% of Houselink participants. Twenty-two per cent of At Home/Chez Soi participants reported Aboriginal status.

Ethnocultural identification also varied across programs: 35% of Houselink participants; 16% of Pathways Calgary participants; 11% of Homebase participants; Pathways Edmonton did not collect this information in a similar way so it is not reported here. Twenty-five per cent of At Home/Chez Soi participants reported ethnocultural status.

Conclusion: Aboriginal people are routinely over-represented among counts of homeless persons. However, the rates reported by Homebase (30%) and Edmonton (35%) are well above norms and above those reported by At Home/Chez Soi (22%). To put this into context, we looked at homeless rates in Calgary and Edmonton to compare them with the rates in this study. In Calgary, the 2014 homeless count reported that 21% of the homeless population was Aboriginal (below that reported by Homebase but in line with Pathways).

In Edmonton, Homeward Trust reported that 46% of its homeless were Aboriginal in 2012, which is higher than that reported by Pathways Edmonton. .

It is understandable that the Toronto group at Houselink would report higher proportion of immigrant and refugee participants than the rest of the country. And likewise reasonable to expect western areas to have a higher proportion of aboriginal people. However, the unduly high rates at Homebase and Pathways Edmonton are not easily understood.

Marital and parental status

Homebase and Houselink had large numbers of participants who were single, never married (96% and 80%, respectively), although the Homebase data did not capture information on those previously married or divorced. Houselink also provides housing for partners and dependents, who comprise 11.5% of the total tenant/member population of the program. Pathways Calgary and Pathways Edmonton had similar numbers of participants who were single, never married but these rates were lower (68% and 62%, respectively). Seventy per cent of At Home/Chez Soi participants were single, never married. The differences in reported marital status may reflect differences in the way that questions were asked, i.e. " have you ever been married?" As contrasted with: "are you married?"

Participants who were parents varied across programs: 31% of Pathways Calgary participants; 16% of Houselink participants; 48% of Pathways Edmonton participants; Homebase did not collect this information. Reports of parental status may be influenced by those who only reported on dependent children – or those currently in their care, rather than all children. Thirty-one per cent of At Home/Chez Soi participants were parents.

Conclusion: Contrary to public perception, many people who have mental illnesses and additions none the less have been in close personal relationships, some of which resulted in them having children. Programs housing those with a mental illness should be prepared to accommodate couples and families with dependents.

Education

The two Calgary programs had similar percentages of participants who did not finish high school (76% for Homebase, 67% for Pathways Calgary), while 48% of participants in Houselink did not finish high school, a large percentage, 52%, attended or completed post-secondary education or training. Pathways Edmonton participants were more evenly dispersed: 26% did not complete high school, 48% completed high school, and 26% attended or completed post-secondary education or training. Among At Home/Chez Soi participants, 55% did not finish high school, 19% completed high school, and 26% attended or completed post-secondary education or training.

Conclusion: Lack of education is a significant issue for all participants as rates of non-completion of high school are well above those in the general population. This influences the ability to obtain vocational training and/or employment that will pay mare than a minimum wage (a necessity for independent housing in the cities in this study).

Military Service

Two percent of Homebase participants reported military service for Canada or an ally, while none of the participants in the other programs had veteran status. Four per cent of At Home/Chez Soi participants were veterans.

Conclusion: In Canada, military service is not a significant contributor to homelessness among those with a mental health and addictions background, as reflected across all programs and the At Home/Chez Soi cohort.

Employment Status

Pathways Calgary and Pathways Edmonton participants had high unemployment (79% and 94%, respectively), but only 34% of Houselink participants were unemployed. Very few

Homebase participants reported on employment status, in the data available, so that information is not included here. Program annual reports suggest that 54% of clients get some income from informal work, panhandling and bottle collection. However, this data is not exactly comparable to questions that ask about employment. Unemployment among At Home/Chez Soi participants was 93%.

Conclusion: Most program participants are unemployed at the two Pathways programs and in the At Home Chez Soi study, supporting other studies that also find a high rate of disability/lack of employment among those with mental illnesses and concurrent addictions. Homebase clients, who do not necessarily have a major mental illness, are more likely to seek some supplementary income from informal sources. Houselink's report of employment is substantial for this client group, with two-thirds reporting some type of employment related activity. In part, probably reflects the programs inclusion of tenants in its program employment, in addition to other training opportunities available. As the client reports from Homebase, Houselink and Pathways Calgary represent part but not all of the client populations of these programs, these results should be interpreted with some caution as there is no certainty that participants in this study accurately represent all persons housed in these programs.

Length of homelessness

Housing availability and affordability is an important determinant of the number of persons with limited income and mental/ health disabilities who are unable to find housing accommodation. This increases the probability of longer periods of homelessness. The following table illustrates the differences in housing challenges in the three cities in this study. Discrepancies are interesting. While Calgary has the lowest vacancy rate, and the highe4st rental costs, it also has the lowest core housing need rate of the three cities. The current robust economic climate in Calgary probably influences the number of people who are in core need as many experience robust incomes and ability to afford housing. The city's growth has also spurred large scale construction of newer housing that would bolster the rate of adequacy and suitability reported. Toronto has the highest vacancy rate but also

the highest core housing need rate, and also has proportionately larger stock of older housing that may fall below adequacy and suitability standards.

Housing Availability and Affordability (2013)

	Calgary (CMA)	Edmonton (CMA)	Toronto (GTA)
Vacancy rate (2013)	1.0%	1.4%	1.6%
Core housing need[20] (% of households)	9%	10.6%	19%
Average rent (1 BR unit)	$1040	$915	$940

Homebase and Houselink participants had similar average longest periods of homelessness prior to entry into program (34 months and 30 months, respectively). The average longest period of homelessness for At Home/Chez Soi participants was 31 months, which is similar to the Houselink and Homebase programs. Pathways Edmonton participants had a much higher average longest period of homelessness prior to entry into the program at 66 months, or 5.5 years. Pathways Calgary did not have this information available but reported that 98% of participants were chronically homeless (at least six months of homelessness prior to program entry). Since response rates are variable, these reported rates of length of homelessness may not be representative of all clients/tenants.

Conclusion: Housing affordability is a major challenge in all three cities. All programs house people who have experienced chronic homelessness for significant periods of time. In one instance (Edmonton) the length of homelessness is double that reported nationally or in the other programs (note – there is no precise information for the Calgary cohort). The Calgary and Edmonton Pathways programs and Homebase were originally targeted to

[20] "Core housing need" is an indicator used by the Canadian government to denote housing does not meet one or more of the following standards: adequacy, suitability, and affordability (30 per cent before-tax income to pay rent and utilities).

reach those with the longest periods of homeless ness and it appears that Edmonton and Homebase did so.

Mental Health Impacts on Functioning

By program requirements, individuals referred to the Pathways programs and Houselink must have a diagnosis of a major mental health disorder (AXIS I under the DSM-IV classification system). This is supported by an intake psychiatric assessment. Extent of the disability or the duration of the illness are not formally factored into this evaluation for eligibility. Homebase has no requirements. While Houselink relied on a reported history of treatment of a mental health disorder, it did not complete a mental health assessment at intake. Both Pathways programs do a comprehensive psychiatric assessment as a component of their intake process. Homebase does not do an intake assessment In order to screen for level of mental health distress, The Colorado Symptom Index (CSI) was completed on the Homebase and Houselink clients who participated in this study. The CSI is a well-established assessment tool with strong psychometric properties that is able to determine the extent to which individuals report symptoms at a level that require clinical intervention/ treatment (Boothroyd & Chen, 2008). A score of thirty or more indicates the need for intervention. The two tables below provide the CSI scores for Homebase and Houselink participants.

Houselink CSI Score

N	Valid	74
	Missing	0
Mean		48.97
Mode		32[a]
Std. Deviation		14.692
Minimum		17
Maximum		79
Percentiles	25	36.50
	50	47.00
	75	62.25

a. Multiple modes exist. The smallest value is shown

Homebase CSI Score

N	Valid	48
	Missing	2
Mean		33.56
Median		33.50
Mode		32
Std. Deviation		11.175
Minimum		14
Maximum		61
Percentiles	25	24.50
	50	33.50
	75	40.50

While there are no mental health acuity measures available for Pathways Calgary, the Edmonton Pathways program collected this information using a different assessment tool, the HoNOS. The HoNOS is a widely used instrument to measure the severity of mental health and addiction problems and it is sensitive to measuring change over time. It is widely used in a number of countries, including Canada, in a variety of mental health settings, and is recommended for use as outcome indicators for severe mental illnesses. They are recommended for monitoring consumer outcomes (Parabiaghi, Kortrijk, & Mulder, 2014). It is a 12-item scale in which each item rates severity on a scale of one to five: where one indicates no problem and four indicates severe to a very severe problem. Thus a total HoNOS score can range from o to 48. Individual item scores over 2 are considered clinically significant. HoNOS items include: overactive, aggressive, disruptive or agitated behavior, non-accidental self-injury; problem drinking or drug taking; cognitive problems; physical illness or disability problems; problems associated with hallucinations and delusions;. problems with depressed mood;. other mental and behavioural problems;. problems with relationships; problems with activities of daily living; problems with living conditions;. problems with occupation and activities. The clients HoNOS scores as intake were reported as follows:

Pathways Edmonton HoNOS scores.					
	N	Minimum	Maximum	Mean	Std. Deviation
HoNOS total score - Baseline	59	9	32	20.32	5.345
Valid N (listwise)	59				

Client mean HoNOS scores were double that for those with psychotic disorders, and significantly higher on almost all measures as compared with other groups with personality and depressive disorders (Parabiaghi et al., 2014) . Thu8si the clients housed in the Pathways Edmonton program were seriously dysfunctional and reported multiple mental health issues.

Discussion: Both Houselink and Homebase participants had CSI scores in the range indicating the need for clinical intervention. Houselink scores are considerably higher than those for Homebase, implying that this cohort is considerably more impacted by mental health issues than Homebase clients. However, of importance is that Homebase clients fall within the clinical range and this supports the program staff impressions that clients are significantly impacted. A more detailed examination of answers to individual questions reveals that Homebase clients report high rates of anxiety depression, and loneliness. They also indicated significant problems with mental confusion and decision making, but these did not correlate with and psychotic symptoms (hallucinations or delusions). In view of the high rates of brain injury and addictions reported by Homebase clients, these symptoms of impaired thinking may related to those conditions of brain injury and substance abuse. However, while this is a possible explanation, the data does not offer definitive proof.

Conclusions: All three programs that measures levels of clinical mental health distress in their clients that we were able to obtain, showed high levels of mental health problems. Because not all programs used the same outcome measures, comparisons are general rather than specific. However, the literature reports substantive reliability of these measures and their results are considered both valid and reliable.

Co-morbid health conditions

Many participants across all programs reported co-morbid physical conditions. Common conditions included asthma, chronic bronchitis or emphysema, and hepatitis C. Between 36% and 60% of participants across programs had a traumatic brain or head injury in the past. These figures are very similar to those reported by At Home/Chez Soi participants. The rate of traumatic brain injury varied, with Homebase reporting a rate near that of the MHCC cohort and the other programs reporting significantly lower rates.

Conclusion: This confirms that these homeless individuals who have co-occurring mental illnesses and addictions challenges also suffer from a range of physical ailments and traumatic brain injuries which are higher than average for those of similar age.

Justice system involvement

Involvement with the justice system was common: 70% of Homebase participants, 95% of Pathways Calgary participants, and 70% of Pathways Edmonton participants were victims of a crime or were either arrested more than once, incarcerated, or served probation in the last six months. In Edmonton, over the previous 12 months prior to program admission the involvement with the police was a n alarming 95% of which 93% involved a court appearance. On the other hand, 36% of At Home/Chez Soi participants reported involvement with the justice system as perpetrator of an illegal activity in the last six months.

Conclusion: Because reports of legal involvement as victim and perpetrator are co-mingled in this data, comparisons cannot be readily made. The differences in rates of involvement with the justice system may be due to the way the information was gathered, participant recruitment during the start-up phase of the program when high needs

individuals were sought out,. Also, the Edmonton program notes that self-reports of justice system involvement differ from independent reports from the policy and emergency services, thus putting the validity of responses into question.

Limitations

This study drew from data collected in the course of "business as usual' for front line service providers working in housing first programs in Calgary and Edmonton. It was supplemented by a client level information collected as a targeted effort at Houselink which provided baseline information on the members/tenants housed in that program. Houselink used peer interviewers in its data collection. Thus data was not collected in the same way and circumstances across all four programs, which may impact its generalizability. Data sets were also incomplete in many instances, which affected the ability to compare on elements of demographics and functional challenges. Finally, not all sites completed identical instruments, limiting cross-site comparisons.

Summary

One of the key issues in this study was to determine if the participating programs served clients with similar or different profiles than those in the At Home/Chez Soi study. The overall data from this study in concur with the client profiles reported from the At Home/Chez Soi study, with variations that may be due to regional differences. A more detailed examination of profiles by study site, as contrasted with the national aggregate sample from At Home/Chez Soi, will be able to further examine the extent of regional variations.

There does not appear to be a distinct demographic pattern that links any specific program with demographics that match the national sample. Some programs are like the At Home/Chez Soi cohort in certain areas such as length of homelessness (Houselink and Homebase), marital status (Pathways Calgary and Pathways Edmonton). Other programs

stand out in a specific feature such as the long length of homelessness for the Pathways Edmonton cohort, their high rate of justice system experience, the numbers who report that they are parents, and their longer and more extensive list of co-morbid health conditions. Houselink stands out for its high proportion of persons with some post-secondary education and currently employed or in training programs, while most of its other demographic characteristics are not markedly different from the other programs of national cohort.

In the At Home/Chez Soi study, participants were evaluated for acuity of need, and divided into high and moderate needs groups, with 38% of participants identified as high need. No such delineation occurred in the present programs and thus it is not possible to determine to what extent the current participants had high or moderate needs. The demographic profiles indicate that life-time substance abuse ranged from 83% to 95% in the present programs and is substantially higher than in the At Home/Chez Soi study. Similarly, justice system involvement is higher in most of the programs.

Data from each program indicates that all four have a housing retention rate, which matches or exceeds that At Home/Chez Soi cohort. Since the aim of all of these programs is help participants achieve stable housing, it appears that each provides this outcome, although they use different organizational and service delivery mechanisms to achieve this goal.

Thus it appears that those people housed in the programs in this study have substantial personal challenges and needs comparable to at least the moderate needs group in the MHCC's study. This if of importance because the current programs report housing retention comparable to those of an initiative that has a high profile, and could have been subject to a "Hawthorn effect". These findings underscore the fact that "housing first" approaches can be highly effective in several formats: those with ACT, ICM and a general case management approach. What may be critical factors in housing retention are additional to those of housing choice, supportive services and tolerance for substance use and may be integrally related to program orientation, philosophy, recovery orientation,

peer integration into program operations, and the presence of a well-developed eviction prevention strategy. All of the latter are essential component of the Houselink program whose retention rate is significantly higher than any reported program examined here or any study of housing retention using any organizational format reported ij the research literature.

While a "housing first" approach to housing with supportive services provides the opportunity for many disadvantaged persons to attain and retain stable housing, various models of support may be applicable to those with different levels of acuity of support need. In this study one clear finding is that a program such as Houselink which assembles a number of programmatic elements in addition to a housing first orientation which include:

- A strong, explicit and implicit recovery orientation woven into program activities and organizational culture
- integration peers into program operations (not merely as advisory)
- development of intentional communities of member/tenants
- organizational culture that views services recipients as partners and "members" who work alongside staff in program delivery.
- Intentional eviction prevention policy

Recommendations:

- Develop a cost-comparative analysis of Houselink, Homebase and Pathways style housing first programs.
- Identify and encourage use of instruments that can easily determine level of acuity of need so individuals can be assigned to ACT, ICM or CM organized services.
- Encourage a unified standard for reporting housing/residential stability.
- Examine the organizational aspects of housing programs (how services are delivered, not what services are delivered) and their correlation with outcomes.

- Support the development of specialized training and support for services delivery staff.
- Assist housing providers in developing a models of housing that include a fully integrated philosophy of recovery, substantive inclusion of those with lived experiences in program governance and operations, and the development of intentional communities.

Table 1. Participant characteristics, by program.*

	Homebase N=50 %	**Houselink** N=74 %	**Pathways Calgary** N=75 %	**Pathways Edmonton** N=75 %	**At Home/Chez Soi** N=2,148 %
AGE GROUPS					
34 or younger	24	6	23	21	33
35-54	39	56	61	66	57
55 or older	37	38	16	13	10
GENDER					
Male	78	53	77	52	67
Female	22	47	22	48	32
Other	0	0	1	0	1
COUNTRY OF BIRTH					
Canada	100	70	81	--	81
Other	0	30	19		19
ETHNIC STATUS					
Aboriginal	30	5	13	35	22
Other ethnocultural	11	35	16	--	25
MARITAL STATUS					
Single, never married	96	80	68	62	70
Married or common-law	4	0	0	4	4
Other	0	20	32	34	26
PARENT STATUS					
Any children	NA	16	31	48	31
EDUCATION					
Less than high school	76	47	67	26□	55
High school	12	1	19	48□	19
Any post-secondary	12	52	14	26□	26
Prior military service (for Canada or ally)	2	0	0	0	4

Currently unemployed	Too few valid responses	34	79	94	93
Longest Period Of Homelessness In Months (lowest and highest rounded to nearest month)	34 (0-60) n=16	30 (0-300) based on n=27	--	66 (2-360) n=45	31 (0-384)
Living arrangement before program entry: **Shelter** **Institution** **Doubling up – friends and family** **Transitional housing &unspecified**	41 26 19 14	Not reported	45 36 4 15	59[21] 24 23	
Reported history of substance abuse **Past month** **Past year** **Life time**	69 88 92	50 63 83	54 66 89	51 77 95	67
Serious Physical Health Conditions **Asthma** **Chronic bronchitis/emphysema** **Hepatitis C** **Hepatitis B** **HIV/AIDS** **Epilepsy/seizures**	23 12 28 0 0 8 24	26 12 10 0 3 15 3	25 13 18 10 3 10 8	38 21 52 0 5 0 12	24 18 20 3 4 10 7

[21] Some reported more than one type of accommodation in the period immediately preceding program entry.

Heart disease **Diabetes** **Cancer**	8 4	30 16	1 3	17 0	9 3
Traumatic Brain/Head Injury **Knocked unconscious one or more times**	60	36	37	45	66

Figures are estimates due to differences in coding the education variable by Pathways Edmonton compared to other programs.
* All percentages reported reflect valid, non-missing data. In some cases, large portions of missing data may skew percentages

Appendix A

Pathways to Housing Program Criteria[22]

Housing Choice & Structure

1. **Housing Choice.** Program participants choose the location and other features of their housing.
2. A] **Housing Availability (*Intake to move-in).*** Extent to which program helps participants move quickly into permanent housing units of their choosing.

   B] **Housing Availability (*Voucher/subsidy availability to move-in).*** Extent to which program helps participants move quickly into permanent housing units of their choosing.
3. **Permanent Housing Tenure.** Extent to which housing tenure is assumed to be permanent with no actual or expected time limits, other than those defined under a standard lease or occupancy agreement.
4. **Affordable Housing.** Extent to which participants pay a reasonable amount of their income for housing costs.
5 **Integrated Housing** Extent to which program participants live in scatter-site private market housing which is otherwise available to people without psychiatric or other disabilities.
6. **Privacy.** Extent to which program participants are expected to share living spaces, such as bathroom, kitchen, or dining room with other tenants.

Separation of Housing & Services

7. **No Housing Readiness.** Extent to which program participants are not required to demonstrate housing readiness to gain access to housing units.

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[22] [22] Tsemberis (Tsemberis, 2011

8. **No Program Contingencies of Tenancy.** Extent to which continued tenancy is not linked in any way with adherence to clinical, treatment, or service provisions.
9. **Standard Tenant Agreement.** Extent to which program participants have legal rights to the unit with no special provisions added to the lease or occupancy agreement.
10. **Commitment to Re-House.** Extent to which the program offers participants who have lost their housing access to a new housing unit.
11. **Services Continue Through Housing Loss.** Extent to which program participants continue receiving services even if they lose housing.
12. A] **Off-site Services.** Extent to which social and clinical service providers are not located at participant's residences.

    B] **Mobile services.** Extent to which social and clinical service providers are mobile and can deliver services to locations of participants' choosing.

Service Philosophy

13. **Service choice.** Extent to which program participants choose the type, sequence, and intensity of services on an ongoing basis.
14. **No requirements for participation in psychiatric treatment.** Extent to which program participants with psychiatric disabilities are not required to take medication or participate in psychiatric treatment.
15. **No requirements for participation in substance use treatment.** Extent to which participants with substance use disorders are not required to participate in treatment.
16. **Harm Reduction Approach.** Extent to which program utilizes a harm reduction approach to substance use.
17. **Motivational Interviewing.** Extent to which program staff use principles of motivational interviewing in all aspects of interaction with program participants.
18. **Assertive Engagement.** Program uses an array of techniques to engage consumers who are difficult to engage, including (1) motivational interventions to engage consumers in a more collaborative manner, and (2) therapeutic limit-setting interventions where

necessary, with a focus on instilling autonomy as quickly as possible. In addition to applying this range of interventions, (3) the program has a thoughtful process for identifying the need for assertive engagement, measuring the effectiveness of these techniques, and modifying approach where necessary.

19 **Absence of Coercion.** Extent to which the program does not engage in coercive activities towards participants.

20 **Person-Centered Planning.** Program conducts person-centered planning, including: 1) development of formative treatment plan ideas based on discussions driven by participant's goals and preferences, 2) conducting regularly scheduled treatment planning meetings, 3) actual practices reflect strengths and resources identified in the assessment.

21 **Interventions Target a Broad Range of Life Goals.** The program systematically delivers specific interventions to address a range of life areas (e.g., physical health, employment, education, housing satisfaction, social support, spirituality, recreation & leisure, etc.).

22 **Participant Self-Determination and Independence.** Program increases participants' independence and self-determination by giving them choices and honoring day-to-day choices as much as possible (i.e., there is a recognition of the varying needs and functioning levels of participants, but level of oversight and care is commensurate with need, in light of the goal of enhancing self-determination).

Service Array

23. **Housing Support.** Extent to which program offers services to help participants maintain housing, such as offering assistance with neighborhood orientation, landlord relations, budgeting and shopping.

24. **Psychiatric Services**.

Extent to which the program provides has strong linkages, provides active referrals and conducts follow-up for the provision of psychiatric services. Specifically, the program: 1) has established formal & informal links with several providers, 2) assesses participants to match needs & preferences to providers, 3) assists participants in locating, obtaining, and directly introducing participants to providers, and 4) conducts

follow-up including communicating/providing consultation with other providers regarding services on a regular basis and coordinating care.

25. **Substance Use Treatment.** Extent to which the program provides has strong linkages, provides active referrals and conducts follow-up for the provision of substance abuse services. Specifically, the program: 1) has established formal & informal links with several providers, 2) assesses participants to match needs & preferences to providers, 3) assists participants in locating, obtaining, and directly introducing participants to providers, and 4) conducts follow-up including communicating/providing consultation with other providers regarding services on a regular basis and coordinating care.
26. **Employment & Educational Services.** Extent to which the program provides has strong linkages, provides active referrals and conducts follow-up for the provision of employment & educational services. Specifically, the program: 1) has established formal & informal links with several providers2) assesses participants to match needs and preferences to providers, 3) assists participants in locating, obtaining, and directly introducing participants to providers, and 4) conducts follow-up including communicating/providing consultation with other providers regarding services on a regular basis and coordinating care.
27. **Nursing/Medical Services.** Extent to which the program provides has strong linkages, provides active referrals and conducts follow-up for the provision of nursing/medical services. Specifically, the program: 1) has established formal and informal links with several providers, 2) assesses participants to match needs and preferences to providers, 3) assists participants in locating, obtaining, and directly introducing participants to providers, & 4) conducts follow-up including communicating/providing consultation with other providers regarding services on a regular basis & coordinating care.
28. **Social Integration.** Extent to which services supporting social integration are provided directly by the program. 1) Facilitating access to and helping participants develop valued social roles and networks within and outside the program, 2) helping participants develop social competencies to successfully negotiate social

relationships, 3) enhancing citizenship and participation in social and political venues.

29. **24-hour Coverage.** Extent to which program responds to psychiatric or other crises 24-hours a day.
30. **Involved in In-Patient Treatment.** Program is involved in inpatient treatment admissions and works with inpatient staff to ensure proper discharge as follows: 1) program initiates admissions as necessary, 2) program consults with inpatient staff regarding need for admissions, 3) program consults with inpatient staff regarding participant's treatment, 4) program consults with inpatient staff regarding discharge planning, and 5) program is aware of participant's discharge from treatment.

Program Structure

31. **Priority Enrollment for Individuals with Obstacles to Housing Stability.** Extent to which program prioritizes enrollment for individuals who experience multiple obstacles to housing stability.
32. **Contact with Participants.** Extent to which program has a minimal threshold of non-treatment related contact with participants.
33. **Low Participant/Staff Ratio.** Extent to which program consistently maintains a low participant/staff ratio, excluding the psychiatrist and administrative support.
34. **Team Approach.**
35. **Frequent Meetings.** Extent to which program staff meet as a team to plan and review services for program participants.
36. **Weekly Meeting/Case Review (Quality):** Serves the following functions: 1) Conduct a brief but clinically relevant review of ½ caseload; 2) Discuss participants with high priority emerging issues in depth to collectively identify potentially effective strategies and approaches; 3) Identify new resources within and outside the program for staff or participants; 4) Discuss program-related issues such as scheduling, policies, procedures, etc.
37. **Peer Specialist on Staff.**
38. **Participant Representation in Program.** Extent to which participants are represented in program operations and have input into policy.

Appendix B: Evaluation Criteria

Program Guidelines

Program Name	***The Alex Pathways to Housing (Calgary)***
Client focus (e.g., individuals experiencing severe mental illness, individuals with concurrent disorders, etc.)	individuals experiencing severe mental illness, individuals with concurrent disorders,
Client exclusions	Lack of a mental health diagnosis Parents with children Usually unable to accommodate couples
Housing model (e.g., scattered site vs. congregate care)	Scatter site
Supports offered (e.g., ACT/ICM team, etc.)	ACT Team
Unique attributes (i.e., why it should be included in this evaluation, what makes the program distinct)	Housing program established according to HF program guidelines described by Pathways NYC. Program based in a health centre Has been in existence 5 years (stable) Only HF program of its kind in Calgary*
Program Name	***Pathways to Housing Edmonton***
Client focus (e.g., individuals experiencing severe mental illness, individuals with concurrent disorders, etc.)	Individuals experiencing severe mental illness, individuals with concurrent disorders
Client exclusions	Lack of a mental health diagnosis Parents with children Usually unable to accommodate couples
Housing model (e.g., scattered site vs. congregate care)	Scatter site
Supports offered (e.g., ACT/ICM team, etc.)	ACT team

Unique attributes (i.e., why it should be included in this evaluation, what makes the program distinct)	Housing program established according to HF program guidelines described by Pathways NYC. Program based in a health centre Has been in existence 4 years (stable) Only HF program of its kind in Edmonton*
Program Name	***Home Base***
Client focus (e.g., individuals experiencing severe mental illness, individuals with concurrent disorders, etc.)	Individuals experiencing severe mental illness, Individuals with concurrent disorders
Client exclusions	A major mental health diagnosis Single persons only: Unable to accommodate couples or parents with children
Housing model (e.g., scattered site vs. congregate care)	Scatter site
Supports offered (e.g., ACT/ICM team, etc.)	ICM team
Unique attributes (i.e., why it should be included in this evaluation, what makes the program distinct)	Program based in a health centre Only HF program of its kind in Calgary. Has been in existence 5 years (stable)
Program Name	***Houselink***
Client focus (e.g., individuals experiencing severe mental illness, individuals with concurrent disorders, etc.)	Individuals experiencing severe mental illness, individuals with concurrent disorders
Client exclusions	Lack of a mental health diagnosis Couples and parents with children are accommodated.
Housing model (e.g., scattered site vs. congregate care)	Scatter site and congregate care
Supports offered (e.g., ACT/ICM team, etc.)	Case management. Peer staff included in staffing

	component
Unique attributes (i.e., why it should be included in this evaluation, what makes the program distinct)	Has been in existence 38 years (stable) Independent organization (not under the umbrella of another) Uses a HF approach, employs consumers Recovery focus embedded in organizational philosophy and practices Houses individuals and couples (a few families where one person has a major mental disorder) Long-term stability with low tenant turnover

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