COMPARISON OF FOUR HOUSING FIRST PROGRAMS

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Note: The program data for this study was collected in 2013 and client data collection for all programs was completed in April 2014. Subsequently, program organization details in some programs have been modified (eg. team organization, development of a housing support team, staff training). The information reported here reflects program operations

at the time of data collection in each program. This present version reflects editing and clarification of the original report.

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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.

Contents

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 are explored before presenting 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 persons served 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, the 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 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).

The operating definition of "housing first" used in this study consisted of the main principles for this approach to providing rapid housing for homeless individuals: 1] rapid re-housing of homeless persons; 2] no pre-requisites for demonstration of "housing readiness"; 3] no requirements for treatment compliance as a condition of housing tenancy; 4] no requirements for abstinence from substances as a condition of tenancy; 5] support services provided on an individualized basis for clients; 6] affordable housing is ensured through rental supplements, as needed; 7] support services are not integral to the physical location of the housing (on-site treatment); 8] housing location, by choice, is preferably in scatter-site apartments but may be in alternative settings based on client preferences.

Background

Since deinstitutionalization, the belated and limited responses by various government agencies (health, housing, incomes supports) to the needs of those living with a mental illness (MI) and substance use (SU) problems have resulted in enormous gaps between client need and service availability (Government of Canada, 2009) (Waegemakers Schiff, Schneider, & Schiff, 2008). The ongoing trend towards community treatment has resulted in many persons who had become dependent on the care of others thrust ejected 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 typically focused on clinical results such as reduction in symptoms, hospital care, decreased 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 stemming from mental illness and co-occurring addictions (Jans, Stoddard, & Kraus, 2004), (Mojtabai, 2011). Together, prevalence and disability necessitate this creation of 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 placed on them for compliance with housing rules (Srebnik, Livingston, Gordon, & King, 1995; Tsemberis, Gulcur, & Nakae, 2004). Consequently, 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 demonstrates that not all those who have had a mental illness remain in supportive housing, for some because it is too restrictive, and for others, because it does not provide enough supports (Leff et al., 2009; Wong, Filoromo, & Tennille, 2007). Others issues include the extent to which programs support a focus on recovery from serious mental illnesses and the degree to which consumers are incorporated as peer supporters in the programs (Davidson et al., 1999).

Some factors impact housing retention. For example, 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 homeless population. The key issue rests in the balance between providing an optimal level of support to prevent homelessness, without providing more support than is necessary so that programs remain 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 evidence on what works, and for whom, has most often neglected to detail the aspects of programs that assure success (Mowbray, Holter, Teague, & Bybee, 2003; (Tabol, Drebing, & Rosenheck, 2010). Program descriptions in the literature, infrequently attribute success to such 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 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, and which provide housing without treatment or abstinence requirements. They follow a harm-reduction approach by prioritizing housing, ensuring personal safety and domicile security without requiring sobriety, or engagement in psychiatric treatment. Such programs also adhere to a consumer preference model of location of housing in so far as is logistically and financially possible.

In over 12 publications between 1999 and 2009, on one or more aspects of the 'Housing First" initiative, none involved a program evaluation of either implementation or program processes, although excellent outcomes were presented. This left policy and program leaders with vague and indeterminate guidelines with which to develop 'Housing First' programs 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 study 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 comprise 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 in 2007, 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 (Calgary) was established at about the same time (2009) 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 provides 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. Houselink (Toronto) was identified independently by the lead researcher as a *"housing first"* program with aspects unique to the Canadian context. It also has demonstrated organizational maturity, providing *"housing first"* and employing a peer model of client/member engagement for over 37 years.

The program evaluation component included data from multiple 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.

The program level 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 affected referral and intake dynamics as well as program operations. While this study can provide a baseline for existing protocols and procedures at the time information was collected, further work is necessary to track the impact of changes on program efficiency and effectiveness.

Because only national level data from the MHCC study was available at the time of preparation of this report, the comparison of client level characteristics and program outcomes of these programs with that reported by the At Home/Chez Soi study is limited to data available from the national report. Program outcomes from the individual sites were unavailable at the time of report preparation. As participant characteristics and program outcomes may vary across different sites may vary, any comparison of Houselink data to the MHCC study is best made in a future analysis of the Toronto data of the At Home Chez Soi research. (This analysis does not affect the Calgary and Edmonton programs as these cities were not sites in the At Home Chez Soi study.)

Program Descriptions

HomeBase

HomeBase (Calgary) is a housing program, operating on *"housing first"* principles, which targets the housing needs of chronically homeless individuals who do not have a persistent major mental illness, and thus fall outside of the scope of the Pathways to Housing (Calgary) program. Pathways clients must have both 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 have no history of formal psychiatric treatment but do have severe addictions issues. Homeless individuals in Calgary who are 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]

[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.

Organizational Auspices

HomeBase is one of two *housing first* programs under the organizational auspices of the Alex Health Centre (Calgary). 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 by addressing both health and social issues.

In 2006 HomeBase (Calgary) 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 Health Centre 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 or in other locations in the community that are of travelling convenience to clients.

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 psychiatric or addictions assessments.[2] Thus, the program finds itself with clients who meet criteria for other programs but once admitted to HomeBase, are retained as clients. Another issue reported by program staff is that the Pathways program ends up housing people whose primary dysfunctions are due to personality disorders, and who consequently demonstrate 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 behavioural challenges, clients with severe personality disorders are reported to absorb an undue amount of program resources.

[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.

Program Qualitative Descriptors

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

- Clients will remain stably housed
- 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 that serve the homeless. They can also be self-referred. The referral process has recently changed. Until late 2013, HomeBase conducted its own screening and intake, including maintaining a wait list. However it 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 general screening and assignment by this centralized group, the HomeBase 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.

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

HomeBase services are provided five days a week (Monday – Friday) during normal business hours. Emergencies are handled by the local Distress Centre if they are of a mental health/addictions nature. No emergency services are offered by HomeBase. Instead services consist primarily of case management and referral. HomeBase 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).

The HomeBase program is organized into two teams of case managers, each with a supervisor. Clients are assigned to case managers who each maintain a client load of approximately 13 to 17 clients. While the teams are organized for supervisory and management purposes, the case managers do not share clients. Case managers support each other, but this support is nominal as the direct service provision for clients falls to the case manager assigned to specific individuals. There is no team sharing of workload or responsibilities.

The immediate goal of the HomeBase program is rapid re-housing in accommodation that is within acceptable limits of space and location. However, 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 client 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 stabilize, in their housing. Frequency of contact and duration of contact with case managers are not linked and there is also no record that reports these individually Therefore, case manager-client contacts may be as short as 15 minutes or last over an hour. Emergencies complicate calculations of contacts.

Housing Options

All HomeBase clients are housed in apartments in various locations throughout the city. Leases are negotiated directly with or by clients, who are the lease holders. Staff assist in the lease agreement 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 apartment units. Housing is scatter-site and case managers try avoid housing in buildings that already have a number of other clients. Housing in located by case managers and housing location specialist

Discharge criteria.

Although HomeBase was organized to provide supports for one year after housing was obtained by a client, at the present time, there are no distinct exit 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 of program success 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 instances in which individuals have been re-housed six or more times. Landlord evictions are the most common reason for being re-housed and they often stem from illegal activity (i.e. drug dealing) on the part of tenants. Hoarding and poor sanitary behaviours leading to unsanitary conditions and health code violations are examples of other, but less frequent reason for housing loss. Although it is not a legal reason 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. Others default on rent payments and are evicted for rental arrears. Although the agency pays the rent supplement automatically, because no

arrangements are made for automatic withdrawal of rent from personal bank accounts when monthly social support cheques 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 individuals and has sparked a decision 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 included the frequency and regularity with which contact was expected of case managers with clients. Additionally guidelines existed but there were no clear policies about the length of time an apartment would be maintained if a client was institutionalized, either in hospital or jail. Moreover, there was no mechanism to transfer/refer those more suitable clients to the Pathways program.

The Calgary Homeless Foundation, which funds both Pathways and HomeBase, introduced a detailed case management guidelines manual with the expectation that all funded programs would ensure that staff are trained in case management protocols and procedures. While adherence to the guidelines is progressing, the extent to which all staff in the program have been trained in case management protocols and adhere to its guidelines remains unclear.

Staffing

As mentioned, until recently HomeBase staff consisted 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 HomeBase This led to challenges in the supervision of direct services staff and service delivery with clients. Most of the direct service staff had a BA (a

few had a diploma in human services or social work), but lacked substantive education and 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), HomeBase has not taken advantage of this opportunity and most staff receive their orientation and training on the job.

Moreover supervisors lack substantive training in the various aspects of services delivery 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 sector and is 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 is an important component of staff support (Olivet, Grandin, & Bassuk, 2010). These meetings require regular supplements with staff training and development in all areas of client functioning and service delivery. It is one area where the HomeBase program could be enhanced.

Client involvement in program operations

Staff are not recruited from client rosters and no clients are employed by the HomeBase program. There are no committees or groups comprised of clients that act in an advisory capacity to the program. Some client satisfaction measures are collected as part of the HomeBase mandate with the Calgary Homeless Foundation, but the program lacks a feed-back mechanisms 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* (rather than *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 HomeBase 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 when staff are expected to meet with a client alone with a client who poses safety risks because of erratic behavior. The laissez-faire leadership style of the original program director appears to have resulted in client needs and preferences being responded to at organizational and staff expense. Thus numerous re-housing efforts have been necessitated because of the nature 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 recognized the cost of client dysfunction as a problem area and has made efforts to change the leadership and shift operational practices. However it is too early to assess the impact of these changes.

HomeBase has experienced significant staff turn-over which may be related to both the previous leadership style as well as the lack of training and in-house staff development both of which serve as important staff supports. Burn-out is anecdotally reported and attributed to the ceaseless demands of some dysfunctional clients. However, research promoting the impact of supportive clinical supervision on reducing burnout (Acker, 2012) suggests that HomeBase may fare better with new focused leadership. Unlike the Pathways program, HomeBase does not have the funding or resources to support active and intensive staff training and support activities that could serve as a preventative measures to mitigate burnout.

Staff demoralization also appears to be influenced by the (accurate) perception that by comparison, the Pathways program is a more fully resourced program with in-house medical and psychiatric staff while HomeBase has to find these resources in the community, enduring long waitlists for psychiatric and medical services that leave staff dealing with mental health emergencies without professional assistance. While this

inequality results primarily from differences in funding provided by the CHF, the front-line staff are not cognizant of that 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. Thus, 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 tighter policies and procedures, which are not completely formulated. Thus, it is premature to comment on what impact the new policies will have. However, some issues and challenges relating to staff training and availability of other agency resources may extend beyond this change.

Houselink (Toronto)

Overview

As 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 since in 1976. 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 considered its mission as housing, rather than treatment and has always used the term tenant (or member as each tenant is a voting member of the corporation/organization) who have a basic human 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 be considered as a front-runner for the development and support of this model of housing for 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 the board consists of agency tenant/members. The agency describes those who are 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. Such positioning of those housed both as tenants and members of the organization establishes Houselink as unique and a forerunner in the delivery of housing services to those with a serious mental illness. Houselink reflects the trend to have consumers included as meaningful peer participants in programs that 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 an ideal 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 empowerment model is the organization's intentional development of a focus on building an intentional community of members, based on the premise that healthy communities create healthy individuals and that community development connects people by building on the strengths of individuals and groups. Recent research in this area supports the importance of intentional communities for those with mental disorders (Pernice-Duca, Case, & Conrad-Garrisi, 2012).

Attention to the impact of organizational culture, what that entails, and how it is infused throughout the culture of the organization is a second important focus within this agency. This area of organizational functioning is as an important aspect of agency health and well-being (Aarons et al., 2012; Waegemakers Schiff, 2009). These two, the culture and its dissemination throughout the organization, aspects are also based on a well-articulated implementation of a recovery-focus for all members. It is unusual to find a program that integrates both 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:

> *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

Organizationally, Houselink has one mission: the housing of individuals 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 recognize and address issues that arise in its older tenants who require 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 (however most do). In the event they do not maintain active contact, an eviction prevention approach is practiced by supportive housing workers who they periodically check-in with 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 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 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 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 Houselink's organizational structure is focused on this mission: "to improve the quality of life for psychiatric consumer/survivors, including those who are homeless or otherwise marginalized, through the provision of permanent, affordable supportive housing and programs." 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 10 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 through public funding and some private donations. The result is a portfolio of 22 buildings in addition to 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)

[4] This total includes family members and dependent children

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 (i.e., Landscaping crews, garbage removal, 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. Houselink has adopted an equity hiring policy and an inclusive employment strategy to help provide opportunities for full-time employment for members. Consequently, since 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 i.e. 39 of 75 FTEs). Staff includes supportive housing workers, community kitchen staff, social recreation and supported employment facilitators, as well as a community development worker and building maintenance staff, all of whom come from a variety of backgrounds including such as 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

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

employment as one of their recovery goals are actively encouraged to seek employment, as appropriate, within the organization. Active staff development and support services are an integral component of the organization. The BOD 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. 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.

Direct service teams are supported by administrative and program staff who organize and oversees the numerous activities that contribute to building community and helping people keep their housing. These activities 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 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 housing options

because of its varied housing units, it does not provide for 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. 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 compatibility. Houselink has a well-defined set of protocols and practices to assure an acceptable housing match in co-op situation.

According to agency policy, members may request relocation to another unit after residing in their current location for a year. While reasons for a relocation request are not a significant factor, 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 exists, the outcome may not necessarily be successful and re-location 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

Core services are offered through housing support workers who help members to handle 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 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, and 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 its activities to assuring that members are securely and safely housed. Members are 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, which 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 follow up 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. Until recently, non-tenant membership was capped at 100, but this cap has been reduced to 50 to 75, and these limits are under review.

What is noteworthy 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 (Waegemakers Schiff, Coleman, & Miner, 2008). The importance of program acceptability to clients (members) is a critical barometer of 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 have not yet been able to document. Out of 486 current tenant/members, 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 totals 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]. Thus the retention rate of that five year plus cohort is even higher than the following chart indicates.

[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.

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**

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 specifies 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 tenants 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 (subject to eviction) . Houselink reports a consistently low annual eviction rate of less than 3% over the last decade.

Houselink as a housing first program

By definition, programs with a *"housing first"* philosophy place priority on housing and individual, without requirements for 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 through a formal agreement with another service provider. Housing is both affordable, usually through the provision of rent supplements, and tenancy is not time-limited. A person can stay as long as he or she wishes. Housing is also by choice: a person chooses, within limits of affordability and availability, the type and location of their housing.

The above descriptors can be applied to Houselink, with one caveat. Houselink deviates from formal program standards promoted by *"housing first"* programs (such as Pathways to Housing in New York) 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 an assumption that this model is preferred by all mental health consumers. By 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 offer 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 since 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 do not specify the number of re-housing attempts that are realistically possible and affordable as each move

requires use of funding resources allocation that decrease the organization's ability to afford resources for supporting the housing costs of additional individuals and thus 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 and limitations 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 such as Pathways 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 Houselink is a housing agency that supports 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 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 Houselink 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 (Calgary)

The Alex Pathways (Pathways to Housing) is one of two *"housing first"* programs under the organizational auspices of the Alex Health Centre (The Alex) (Calgary). The Alex is a multi-program health care agency whose mission is: "*delivering innovative and accessible health and social solutions."* For over 40 years, The Alexander Health Centre (The Alex) has had 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, The Alex 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 who were absolutely homeless. This invitation led to the development of The Alex Pathways to Housing, modeled after its new York city counterpart, as a comprehensive program that included housing and supports provided by an assertive community treatment team. The program began operating in 2007 and currently serves over 170 clients.

Program Description:

The Alex Pathways operates as a separate and distinct program within the Alex organization, employing a 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 (also operated by The Alex) and Pathways programs occupied the office space in a shared site. A year ago HomeBase relocated to its own space a short distance away.

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, Abbeydale, 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. While clients are seen at these offices, considerable caseworker-client contact occurs 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 reflected 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 Alex Pathways is not a residential program, the assertive community treatment team (ACT) approach includes availability beyond customary business hours. The provision of an ACT team allow the program to offer 24/7 support services. This extension of service availability necessitates organizational flexibility in 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. The Alex Pathways maintains a separate profile from

the other Alex programs, which are located at a 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 The Alex 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 house a number of other clients. The program has 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 self-refer. Until late 2013, The Alex 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 general screening and assignment, the program conducts an agency-specific intake and upon admission, the client is assigned to one of three 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 seven 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 require 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. Concomitantly, for a significant, but unknown number of clients the supports offered by The Alex Pathways may not be replicable in other organizations if these clients 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 due to failure to maintain stability within the Pathways program has been an avenue for a few clients who are unable to function within the program model. As with the program model promoted by Pathways to Housing, NYC, Pathways experiences a failure or drop-out rate of around 13 – 14% of those admitted. Roughly one in every eight clients fails to achieve housing stability in the Pathways program. Currently, no data are available that profiles those who drop out and are discharged because they cease to have contact with staff. 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 behaviours that result in repeated evictions by landlords. Hopefully, forthcoming data will provide greater insight into this cohort.

Program philosophy and operating principles

The Alex Pathways 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. The organization is also built around respect for staff and the need to support staff in their outreach efforts. While peer involvement in this model is mentioned, those with lived experience play a supportive and secondary role as nominal "advisors" in this organization, which has service delivery of support services as its main objective.

The Alex Pathways 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 in 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 diversion away from jail, or planned housing for those with a serious mental illness who are released from jail.

Since its inception (2007), the program has twice experienced a change in leadership. However, the current director of the program has been a staff member with the program from the beginning and has developed a well-articulated program design and staff support philosophy. The 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 Alex Pathways program advocates for 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, based on client need. This funding model allows for, if necessary, multiple housing moves until the appropriate client fit is achieved, and/or the client is able to settle into a stable environment (this sense of permanency can be anxiety-producing for persons who have only known an iterant life-style. Clients need time to make attitudinal and behavioral changes). The program model includes physicians and psychiatrists and thus also facilitates 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.

(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.

On-site services include a medical clinic staffed 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, where clients are contacted at a chosen location 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, and specific services such as 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. As mentioned, 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 Pathways 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, supported by the medical and psychiatric staff. Presently there are three ACT teams; the newest was created in 2013. Each team serves a distinct sub-population: a hospital team that serves those referred from within the Alberta Health Services system, a justice team that 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 that addresses the housing needs of high service users coming from both corrections and hospital services. Clients are screened at central intake (recently created by the Calgary Homeless Foundation) and referred to the appropriate program. Within these three teams, client capacity totals 200 persons. Currently, 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 detailed case management guidelines with the expectation that all funded programs would ensure that staff are trained in case management protocols and procedures. Nevertheless, it is extent to which all staff in the program have been trained in case management protocols and adhere to its guidelines is unclear.

The program operates from offices located in an office amid mixed businesses in the southwest section of the city. Although well-served by bus transit, the office is distant from

the mass transit system, making access is a lengthy for those relying on public transportation. The positive aspect of the location is that it is located close to multiple grocery stores and inexpensive eateries. It is also well away from the city's central core where many of homeless persons congregate around large city shelters and soup kitchens. This location helps clients who are seeking to distance 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 relations in a very tight and competitive housing market. The agency is leaseholder in some instances, and is the lease negotiator with the client as leaseholder, 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 seem to have forestalled potential difficulties and minimized the number of clients facing eviction. With rising rents and a 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 voluntary life-enhancing and social skill-building activities. 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 estranged or lost relatives. The program has also introduced some culturally oriented activities, sponsoring Aboriginal healing circles, sharing circles and a pow-wow. The culturally specific component is unique to the Alex Program. It continues to seek ways to provide programming relevant, appropriate and of interest to clients.

Staff Training and Development

The 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 is important in supporting staff (Olivet, McGraw, Grandin, & Bassuk, 2010). These meetings require regular 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 appears to have had a significant positive impact on Pathways staff. Burnout is not reported as a significant issue, which 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 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 Pathways program by other organizations in different provinces also enhances a positive message to staff as they are engaged 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 existed 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" (program mission statement). 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 agency coordinating homeless responses and funding in Edmonton, and leading the implementation of the city's 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, the Edmonton Pathways program (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 12 months of homelessness, four or more episodes of homelessness within three years, or are being discharged from a psychiatric facility after an extended hospitalization. The program was established at an independent site, close to 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 developed 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 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 operating 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 rental 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. At full capacity the team serves, 77 individuals, some of whom are parents with dependent children.

Program activities consist primarily of individual support sessions, most frequently as outreach calls or home visits. Clients are seen at the office for medication and psychiatric consultation. Some substance abuse counselling is provided, but the substance abuse specialist is primarily involved with front-line outreach and client contact. 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, Boyle McCauley Health Cnetre, which espouses comprehensive and inclusive health services to inner city Edmonton, Pathways to Housing Edmonton 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 was replaced by a person with a legal background as an attorney but no mental health, addictions or social services delivery experience. 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 Pathways to Housing Edmonton program is the rapid housing of persons with a serious mental illness with and without co-occurring substance abuse problems, without requirements of treatment compliance or sobriety to maintain housing. The program follows the organizational policies and protocols of its parent organization

which are expected 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, range 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 includes nursing, medical, and psychiatric staffing. 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 could improve the organization's operations.

Staffing

The ACT team consists of eight persons, a team leader and seven others with a background in social work, psychology, and rehabilitation studies. However, hiring criteria have not required experience in working with seriously mentally ill persons. The lead person of the ACT team had no prior formal mental health and addictions training or experience. The lack of training and experiences by senior staff, has led to challenges in staff supervision, training and support. Ongoing in-service training is supplemented with local conferences and training addresses some of these issues. Direct service staff are assigned to the ACT team which at present serves 75 individuals. Direct staffing is supplemented by a nurse,

and a part-time physician and psychiatrist who address the medical and mental health needs of clients. This staffing ratio is comparable to that found at Pathways programs elsewhere and matches the need for intense services with optimal caseload assignment.

Client Admission Criteria

Eligibility for the Edmonton Pathways program includes being homeless and the presence of a major psychiatric disorder which has resulted in impairments in employment and living. Substance abuse is often co-occurring, but is neither an admission or exclusion requirement. Consequently the program uses a harm-reduction approach to 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 behaviour. However, the program is working on guidelines for accepting and dealing with those with serious anti-social and behavioural problems as the program has encountered a number of instances where some individuals have experienced numerous housing relocations and 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 space is available 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 conducted. Medical and psychiatric evaluations are 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 worker who is a member off the ACT team and who assumes

responsibility for ensuring that all aspects of the assessment are reviewed with the client upon which a mutually agreed on action plan is initiated.

Discharge Criteria

Homeward Trust, the organization that funds the Pathways Edmonton program, has a goal of discharging persons in its *"housing first"* programs within a year. To date, Pathways has not been part of this planned discharge timeline and it presently has an indefinite length of service for clients. Pathways Edmonton continues to face challenges of deciding 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 eviction for a variety of reasons. The program has not yet established criteria for when a person has had an unacceptable number of housing failures and it 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 while it attempts to document reasons for program discontinuation, it does not have precise information on the factors that resulted in discharge of all persons who leave its program. Therefore, it is not possible to determine the extent to which these discharges are for positive reasons as contrasted with those who are unable to abide by minimal program and tenancy requirements.

Recovery orientation and peer involvement in program

Consistent 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 focus is applied by staff in individual contact or through programmatic activities. Because

Pathways has few activities organized for clients, most must seek social, recreational and vocational from other community organizations and programs. The extent of this use of other activities is not documented, and thus it is not possible to determine how far this these extra activities extend 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 follows the norm 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 units of a larger organization, Pathways Edmonton is impacted by the organizational culture of 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 considers delivery of a specific set of services to a targeted 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 in promoting a recovery environment (Davidson et al., 1999; Mowbray, Moxley, Thrasher, Bybee, & Harris, 1996).

The extent to which the ACT team of the program functions as an inclusive and collaborative unit has 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 which has contributed

to higher levels of team cohesion. The audit t recommended that increased integration of the medical staff would contribute to even greater cohesion.

In small organizations and programs, leadership has a direct influence of the organizational culture and climate. For Example, the founding program director had a collaborative working style, which de-emphasized hierarchical structure and encouraged staff involvement in decision-making. It is unknown 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 of the four programs investigated in this study. 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 Table 1.

Table 1

Program Comparison Chart

	HomeBase Calgary	Houselink	Alex P2H Calgary	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

Auspices Organizational	Alex Health Centre	Autonomous 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 - consisting of 50% member/tenants	BOD. No current advisory committee	BOD governance. No program advisory committee
Extent of formal, written program policies on all client and staff activities and program operations	Formal staff policies; program policies under development	Extensive written program policies	Formal staff policies; program policies beyond HF criteria substantially developed	Formal staff policies; program policies beyond HF criteria primarily verbal rather than written
Client involvement in governance	no	yes	no	no
Service recipient involvement in operations	no	yes	no	no
Mental health 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 offices	at program offices
Program activities: offered by program or linkage to local community	local community	program and community	by program	primarily in community
Case management	ICM	Supportive	ACT	ACT

model (ACT, ICM, CM)		Housing Worker		
Client exclusions	No formal mental illness diagnosis, but may have co-occurring mental illness No exclusion for substance use disorders	must have mental illness diagnosis, or evidence of such through a disability and duration No exclusion for substance use disorders	must have a major mental illness diagnosis No exclusion for substance use disorders	must have a major mental illness diagnosis No exclusion for substance use disorders
Landlord arrangements: Program or client hold lease	client	Agency (program)	mixed	Client and co-lease with P2E
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 unable to sustain housing - multiple evictions
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	clearly stated in organizational policies,	yes - evaluated with HF standards	yes - evaluated with HF standards

	for compliance with P2H program standards	protocols and practices.		
Nomenclature for tenants	clients	members/tenants	clients	clients
Self-evaluation	no	Yes	some	some
client satisfaction surveys[10]	no	yes	no	partial
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 or P2H ED has co-lease with client

Summary of Organizational structure and auspices

All four programs are affiliated with organizations that have been in existence since the late 1970s. 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.

[10] All programs conducted some nominal satisfaction surveys and Pathways Edmonton includes this as part of its research studies. We refer here to substantive surveys discussed with clients, and actively used for program improvement and modification.

Three of these programs have been housing persons with mental health issues for at least as long as the At Home/Chez Soi (MHCC study of housing first) sites (approximately five years). The fourth, HomeBase (location), 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 need/high risk individuals who may have significant underlying mental health and addiction problems. [11]

All four programs have additional advantages in being in mature organizations which have existing organizational structures to address program structure and delivery issues. However, Houselink is the only program that 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

The four programs exhibit differences and similarities in program auspices, organizational design, philosophy, and culture. Three programs are units 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 the Alex and Boyle McCauley boards are governance boards and operate at a distance from the day-to-day operations of their

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

programs. All three programs (The Alex Pathways, HomeBase and Pathways Edmonton) have directors who report to the respective executive director of the parent organization. In each instance, the program directors have extensive autonomy in the organization and delivery of services. Liaison with external funders is handled as a mutual role of the executive and program directors. This freedom in managing operations has allowed each director to develop a vision for how *"housing first"* models apply within each program. 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 employed specifically because of their prior client 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. Houselink 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, and reflects the trend to include consumers 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 influences how these functions are implemented. Houselink is the only program that specifically mentions housing as a right as part of its organizational mission statement. Additionally, only Houselink specifically addresses the importance of recovery as a specific goal in its mission statement, accompanied by an explicit recovery policy. It also extends its view of member inclusion in organizational governance and operations 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. 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. Intentional communities bring together people who share similar interests, values, backgrounds, life-styles, and who live in sufficiently close proximity to provide the social cohesion and sense of belonging that arises from this sharing. They increase the social and emotional capital and capcity of its members and provide a sense of belonging which is important to those who seek recovery from mental disorders. 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 integration (Mandiberg & Edwards, 2013; Waegemakers Schiff, Coleman, & Miner, 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 offers a range of activities, house/building meetings and educational events at various locations. Two of the programs, (both Pathways), also operate under the *"housing first"* program model promulgated by Pathway to Housing in New York City. 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 have actively offered priority housing to those who are absolutely homeless (living in shelters and living rough). Finally, supports are provided 24/7.

The other programs operate under a *"housing first"* philosophy but operate under different organizational structures. HomeBase, which does not specifically target those with a major mental health diagnosis, uses an intensive case management approach to service delivery and services are only available during the regular work week. 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. Houselink has no time limits on tenancy or program involvement. , As a landlord and support provider, it 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 retain housing. In the event that the tenancy becomes problematic and eviction becomes a possibility, the supportive housing worker role shift more to assuming a landlord function responding to the breach of the lease while concurrently offering alternatives. This eviction prevention process utilizes staff person specifically trained in tenancy law to intervene in the situation. It also imposes no time limits on length of tenancy and some individuals 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 in which services are provided *to* rather than *with* service recipients. This implies a hierarchical rather than collaborative approach, reflected by 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 in promoting 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 without 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.

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 experience" into the operations of the organization has been part of its fabric since its inception. Thus Houselink has considerable experience in the benefits, and occasional challenges, that inclusion presents. The other programs have yet to establish ways for those with 'lived experience' to be involved in service delivery.

Formalization of policies and procedures.

Each program has both staff and client manuals that 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 formally articulated.. Some of this is evident in the struggle that HomeBase and Pathways Edmonton experience in deciding the number of times and the circumstances under which individuals are re-housed when a placement breaks down, or under what circumstances and what criteria determines when clients are ready for "graduation" from the program. Another example? arises from the programs' vision of the extent to which support services are provided 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 more formalized and limited while those

at Houselink are more extensive in detailing expectations for staff and tenant/members in program-related activities.

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. This has implications for the legal responsibilities that the in each location assumes. HomeBase acts solely as a negotiator in establishing the rental agreement and the client is the signator and lease holder. 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, Houselink is subject to the tenancy act in Ontario.

The Alex Pathways acts as a landlord in many instances; 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 include specifics of how housing responsibilities and disputes are handled. Neither HomeBase nor the Pathways Edmonton programs assume landlord responsibilities. Rather, 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. In Edmonton, a mixed arrangement exists such that either the client holds the lease or Pathways Edmonton has a co-lease arrangement with the client. This arrangement is most often used in instances with new clients where some concern exists about tenant stability.

The issue of whether to act only as a negotiator or to assume responsibilities as lease holder has been an issue of considerable reflection 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 necessity of finding a new suitable, affordable unit in tight housing markets. The Pathways programs, with experience in both models, have considerable practice wisdom in this regard.

Houselink, as landlord for all tenants, possesses a clear set of documents that articulate expectations and responsibilities of tenant members. 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 available course of action for 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 situations, the agency assumes leaseholder responsibilities; thus all tenant issues are handled in a uniform manner. In addition to the dual role tension of being a landlord and support provider in one, Houselink identifies benefits that promote housing retention. That is, when a support or case management relationship is terminated for any reason, and 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 including 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 intended to be fully integrated.

Program admission practices and procedures

"Housing first" programs are expected to house new applicants as quickly as possible and not keep a waiting list. In reality, all programs in this study have limited resources to deal with the onslaught of housing applicants. Intake and waiting lists are handled differently in

the four locations, and extend to three cities which have evolving intake and placement processes.

Until 2009 all of the programs had direct referral and admission practices. Since then three (Houselink, The Alex Pathways and HomeBase) 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 illness and addiction problems who require supportive housing, handles referrals for 29 participating organizations that specialize in supportive housing, including Houselink. Applicants are referred to agencies on a rotating basis. However 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 existence 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 maintains its own waiting list, which depends on the number of allocated 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 of those referred by agencies serving those who are homeless and have mental illnesses and co-occurring addictions problems.

Organizational leadership

Leadership in each program includes a variety of professional backgrounds and thus organizational vision for the program. Pathways Calgary began under the auspices of a physician with no prior mental health services experience. It was transferred, briefly, to an administrator with no mental health experience. Leadership has subsequently been assumed by a psychologist with mental health and community experience who has provided a holistic guiding vision to program development. Pathways Edmonton was developed and led for its first four years by a social worker with substantial mental health experience. Similarly, HomeBase was 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 shifts in the last four years, with each losing its executive director. In Edmonton, the program leadership has been assumed by an attorney. The Pathways Calgary has a director with a MA (psychology, but not clinical psychology). HomeBase is headed by a program manager and both it and Houselink in which social workers are program directors. Houselink continues to be led by an executive director with an MSW.

Leadership turned over twice within a year at the Alex Pathways. This instability was addressed by the appointment to program director of a senior staff who had been with the program since the outset. This person has retained the organizational mission and *"housing first"* philosophy, 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, which has resulted in increased staffing stability.

By comparison, while HomeBase serves the equivalent number of 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 focus 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. The HomeBase staff perceive the differences negatively, and contributing to a less positive organizational climate.

Organizational stability has also been strengthened at Houselink where the retirement of the long-serving executive director and the subsequent replacement culminated in the expansion of some programs and support services while concomitantly increasing organizational capacity in its electronic database. This resulted in an increased ability to report on housing activities and outcomes that allow comparison with other programs.

The founding program director at Pathways Edmonton left the position and was replaced by a person with a legal background but no background in clinical or social services. The learning curve required to meet the challenges of vulnerable persons with complex problems is steep and it is premature to assess how this change will impact the program's operations. 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 to acclimate to the Calgary environment. This director has also been challenged by the large staff turn-over that happened shortly before her arrival, and the ensuing need to re-build the ICM teams in the program. It is too early to assess what impact this change will have on organizational functioning or client outcomes.

The impact of organizational and leadership changes on client experience, satisfaction, and housing stability may not be felt immediately and nor will it be reflected in the annual reports of these programs until later. What is 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 human services backgrounds. 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[12] 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 to plan for daily and weekly activities and priorities with housing, rehousing and emergency client needs. However, the extent to which teams members share clients, with any team member 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 worker. 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 assume primary responsibility

[12] 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.

with workers assigned 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.

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, support worker, or client care coordinator, is assigned to each client. These workers are divided into teams, with each team having between six and 10 workers and 70 and 100 clients per team (depending on the program). The number of clients per worker ranges from 12 to 20 depending on acuity and severity of client need for supports for housing stability.

In HomeBase and Pathways Edmonton, the original organizational responsibilities called for the support worker (HomeBase) or ACT team member (Pathways Edmonton) to be responsible for locating and arranging for housing. Since this study was initiated both these programs have established distinct housing teams that are responsible for locating housing, arranging tenancy, and handling tenancy related issues between the client and landlord. Houselink has a housing tenancy unit that addresses tenancies in both its own and 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 four programs offer a variety of support services and recreational activities, either directly or through arrangements with organizations. They differ primarily in the extent to which the activities are offered directly by the program 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 established formal agreements with mental health service providers for clients to receive needed targeted services 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 Houselink skills and income) food program (which enhance skills, encourage social networks and friendships), and 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 cumbersome due to long wait lists for specialized psychiatric services. The same issue emerges in accessing medical services beyond emergency clinics. HomeBase clients do not have preferred access to the Alex medical clinics and must meet the clinic's eligibility requirements. Most local physicians are not accepting new patients and of the few who are, there is some reluctance to take on patients with complex needs (Hwang, 2001) and a dubious record of treatment compliance that haunts many who have lived on the streets. Thus, clients' medical needs are often adequately addressed. This is a significant issue for many clients who have been homeless for extended periods of time, and who are plagued by numerous unmet medical needs.

Beyond medical services, the programs offer activities related to social, recreational and independent living skills. The Alex Pathways offers a number of different program activities at program offices, cooking and nutrition, money management, as well as pre-

vocational, 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 parenting group. Other activities are primarily through linkage with local organizations.

Houselink provides a range of activities and groups ranging 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 DREEM survey, was a peer-led initiative to learn about member experiences of both recovery and Houselink's recovery-oriented services[13] 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 programs 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.

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

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 (Padgett, Gulcur, & Tsemberis, 2006; Tsemberis & Asmussen, 1999). This includes housing people in their own apartment, room in a house, supportive housing program, boarding house, group home, or long-term arrangements with family and friends. The MHCC At Home/Chez Soi (AHCS) study used similar outcome criteria to determine if participants were stably housed and provided detailed the percent of participants who were stably housed all of the time (62%), some of the time (22%) and not at all (16%) (Goering et al.,2014). While the AHCS study attempted to keep in contact with all participants, some were lost to the study. The ultimate housing status for those lost to the study is thus not always known. Not all of the AHCS sites were able to track indicate housing status for those who leave the study, whether they were in the intervention (housing first) or control (treatment as usual) group. This may lead to an inaccurate assumption that program retention in supportive housing is the benchmark for housing stability. Supportive of this issue of housing retention is Houselink data (five year rates) indicate that some residents move to alternative housing and that program discharge does not imply return to homelessness.

In this report, we examined outcomes of programs that report on clients who remain in the program and remain housed by the program. No follow up was conducted to determine if any people who leave the program also remain stably housed. However, some reports suggested 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, those who are considered program clients regardless of housing status, 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 is to keep people in stable housing. Thus housing retention is the best indicator 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 than long term residential stability. This allows for programs to "graduate" those who move on to other housing choices in their recovery. Keeping this in mind, retention rates are examined 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 housing retention rates ranging from 78% to 86% of total admissions (Waegemakers Schiff & Rook, 2012). These reports usually present the percentage of time that participants were housed over a given time, or percentage of participants housed part of the time (often presented as 50% of total possible days) in a given period of time. The recently released final At Home Chez Soi study reports on those housed continuously (62%) and part of the time (22%) when rates are compared across all study sites. Over the two years of that study, the "housing first" participants spent a total of 73% of their time in stable housing[14]. However, this is not equivalent to presenting the proportion of participant who were housed in stable housing all of the time in that two year period.

[14] This report was prepared before reports from individual sites were available. There may be site specific data that would provide greater details and specificity of differences across participating cities. A comparison of Houselink with Toronto specific data would ultimately be useful.

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. On the other hand, because Houselink is the housing provider, those reported as housed are by definition residing in stable housing 100% of the time. This variation in reporting frames make it difficult to offer true comparisons in housing retention of participants among the programs or with the At Home Chez Soi study which also used a housing stability framework of reporting days housed.

Another issue arises because some programs report on clients who have moved out, but do not necessarily indicate if the move was for to other stable housing, (e.g., moving in with family or a partner or to a different more preferred location), or if the discharge due to repeated evictions, remain connected with case management support, etc. This has been reported as a limitation in housing retention outcomes in other supportive programs (Wong, Poulin, Lee, Davis, & Hadley, 2008). Programs also report that some clients have died, and, 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 reports indicated that 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 impressive for a hard to house client group.

In order to recognize difference in retention rates, we examined both the number and percentage of clients who remain in the program, those who have left for any reason, and 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 includes 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 is presented in Table 2:

Table 2

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[15]	72% retention.	21.7%	78.3%
The Alex Pathways[16]	68% retention	22.9%	77.1%
Houselink[17]	88.5%	4% to 6.7%	93.3% to 96%
HomeBase[18]	92%	18%	70%

The Pathways programs report on those who are stably housed all of the time and represent data over three years of operation. Houselink data represent 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 Home/Chez Soi study reported on the percentage of people housed all of the time, some of the time and none of the time.

[15] 5-year rate

[16] reported rate since program inception in 2009.

[17] represents year-by-year tracking with a significant drop over time.

[18] 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.

This makes comparison with the national study difficult as retention of permanent housing is operationally defined differently.

Table 3

Data used to capture residential stability

Definitions

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 %

Rates for those housed permanently and all of the time, are higher for all of the programs in this study than the 62% rate reported in the At Home Chez Soi project. In part this may be due to the fact that the AHCS programs were undergoing initial development while attempting to achieve housing rates reported by programs with greater longevity (such as the Pathways New York program which has been in existence for at least eight years prior to reporting strong outcomes). Houselink, on the other hand, has the strongest and longest

documented retention rate of the four programs, exceeding that reported in other "housing first" programs. It retains 88.5 % of member-tenants in housing, a rate that rises to between 93% and 96% when planned exits for alternative housing and client deaths are factored in. These rates are consistent over the last five years. One lesson from these outcomes 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 reported longer stability than the At Home/Chez Soi programs. They were also components of long-established organizations. This long-term organizational stability is also a possible positive factor in Houselink operations, which is supported by a clear organizational mission to include tenant/members in organizational governance and operations. This need for organizational development is a factor that has not been taken into account in the existing reports of "housing first" programs. Thus, retention rates may possibly rise once these programs are more fully mature.

One additional factor that may influence retention rates involves the "Hawthorne effect", that is the extent to which outcomes are influence by participants' behaviour because they are aware that they are part of a study. While the AHCS outcomes data may be subject to this influence, none of the programs in this report was part of a research study. The reported the retention rates in housing of the programs in this report 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 and is not influenced by being a participant in a research study. The same cannot be asserted for the Pathways model programs either the New York based study or the At Home/Chez Soi study.

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" 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 developed by the Pathways (NYC) staff and applied to both the Calgary Alex and Edmonton Pathways programs. Both were reported to be in high compliance with the criteria.

While HomeBase uses a *"housing first"* philosophy, it does not employ an ACT team, and 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 for Pathways model programs do not require ACT teams but include the use of 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 of health care in Alberta. Because the guidelines regarding formal service agreements for medical and psychiatric services were formulated for an American health care system, these guidelines are not as easily adapted to a Canadian and Alberta context.

Some of the Pathways guidelines are most applicable to clients with serious mental illness and addictions and do not lend easily 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. Provision of ancillary services is also not embedded in the HomeBase program model, because its focus is on housing and supports to maintain housing. HomeBase does, however, have a strong commitment to re-house in the event of housing failure. As its annual report attests, this commitment requires a reassessment because as some persons have been re-housed numerous times, repeatedly failing to take responsibility for appropriate tenant activities and their evictions have consumed 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 scatter-site housing is more feasible than purpose-built units and is most often the norm. It also fits with a relatively young agency that has to rely on rental agreements to access housing. Houselink's enduring existence has allowed it to acquire most of its own housing, creating 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 is not unique to the mental health consumer community. While communal 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 in which 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 and an emphasis on developing intentional communities. This recovery philosophy is embedded in formal policy and implemented

through activities designed to enhance the functioning and lives of members, including both member and staff training in recovery. It also uses a recovery, lens strength-based approach to utilize funder required assessment tools, as exemplified though its DREEM study of recovery practices (Houselink Community Homes, http://new.houselink.on.ca/wp-content/, 2011, 2010). It is a holistic and integrated model of housing for mental health consumers. While other programs espouse a recovery orientation, there are no specific or discrete activities or documentation in these other programs that demonstrate how this orientation is implemented.

The most substantial indication of program effectiveness for housing programs is tenant/client retention. In that regard, Houselink outperforms the other programs and the At Home/Chez Soi programs. It has a long-standing history of housing retention by tenants that is not influenced by a temporary shift in housing availability or staff practices. This retention rate may also be impacted by tenant/members (Houselink) who do not have as extensive a history of homelessness as the other programs. However, this relationship needs further investigation. The research literature does not indicate to what extent a history of prior homelessness is a significant predictor of housing loss for those with concurrent mental health and addictions disorders who are re-housed. While Houselink presents a model of inclusion and recovery that exceeds other housing approaches for persons with mental illnesses and addictions, there continues to be some question about the extent to which the AHCS study group may have been less functionally able to retain housing. This is examined further in the following section on client characteristics.

Client characteristics: A comparison across programs

A further objective of this study was to examine client demographics across programs and to compare these them with those housed in the At Home/Chez Soi study conducted by the Mental Health Commission of Canada (MHCC). The following section presents results of

data collection and analysis across programs and also 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 existed for at least five years (e.g., Houselink has been in operation for over 37 years) and thus have moved beyond the implementation phase 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 reports from the field that each program addresses different sub-groups of this high risk (for homelessness) population.

Prior to this study, senior research staff from At Home/Chez Soi assisted the two Pathways programs to select a set the data instruments from the AHCS study, which could be easily administered. 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 funding for these tasks. 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 paid a nominal stipend for their time at each data collection point. By comparison, 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 in the present programs. For the three Alberta programs, questionnaires were administered at baseline, 6 months, 12 months, 18 months, and 24 months following enrollment in the program[19], 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 analysis

Quality and completeness of data varied across programs and across variables. Data completeness was the biggest concern as large numbers of missing data made it difficult to determine if the results were representative of the entire sample. In some cases, it was also difficult to discern whether a participant did not answer a question or if missing values indicated a negative response. The quality of data entered was generally robust, although

[19] 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.

there were some instances of mixed numerical and text entries within the same variable. One limitation is that some programs collected data retrospectively, but did not provide an indication of when, in the process of securing or establishing housing, this retrospective data collection occurred for a specific participant. This makes it difficult to truly compare baseline information across programs, or to track progress over time because baseline does not necessarily indicate the point of entry into the program. However, the data does provide a demographic overview of clients served across all programs.

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

Participant profile/demographics

The number of participants ranged from 50 for HomeBase to 74 for the two Pathways programs and 74 for Houselink. All Pathways and Houselink participants had a history of a mental illness and a diagnosis of a major mental illness. A co-occurring addiction disorder was not required, but a lifetime history of substance abuse was reported by between 83% and 95% participants.

Ages ranged from 21 to over 67, with most reported as middle-aged (35 to 54). All participants 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 and the program began to collect client data systematically in 2011. Although at the time of this study, HomeBase has over 158 housed

clients, the program was able to provide a relatively complete data set on 50 participants. Of these participants, 78% were male and the average age was 42 (range 20 to 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.

A large 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 childhood.

Twelve per cent of participants completed high school, 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, most of which was from casual employment, often from activities such as bottle picking. At program entry, 45% reported no income, 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 (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 continuous 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, 25% had court appearances within the last year.

Sixty per cent of HomeBase participants completed information on a baseline co-morbid conditions questionnaire. Participants 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 previous 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 mean QOL score of 82.3 (range 43-127, sd 23.4). The total score was also strongly positively correlated with the global measure of quality of life ($r= .693$, $p<.001$) .

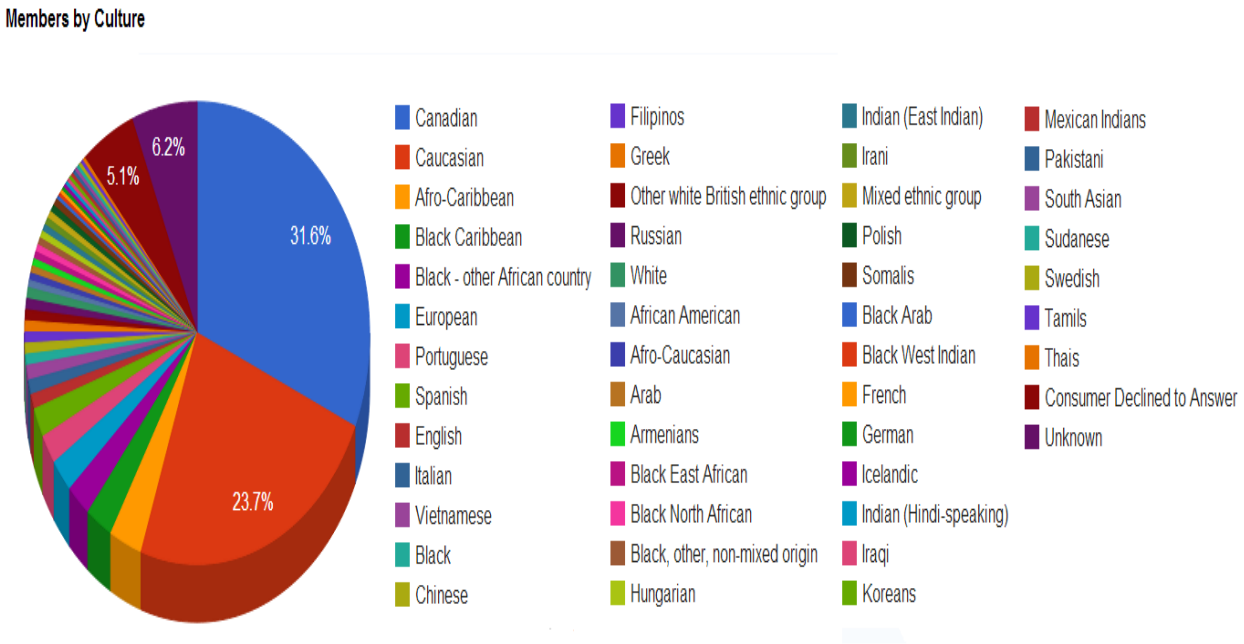
The GAIN is a questionnaire on substance use. It contains five questions about substance use that are used to determine if the participant has a history of a substance use disorder in the past month, in the past year, and over their lifetime. Within each time period, a higher score indicates more affirmative 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 were 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 had 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 be engaged in formal interpersonal relationships (marriage or common law) or to be parents. They present with chronic health conditions and report a high rate of traumatic head injury. They are quite likely to have been involved in the justice system over the last year (as perpetrator)**.**

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 in the population and in other programs. The average age was 50 (ranging from 21 to 68). Seventy per cent were born in Canada, 5% reported Aboriginal status and 35% reported other ethnocultural status. None of the participants reported prior military service. The following chart, and a similar one for Pathways Edmonton clients on page 85 present graphically depict the programs, client ethnic and cultural diversity. These are intended to illustrate this diversity and not to analyze its implications.



Most participants were single (80%) and 16% reported having children.

One per cent of participants stated that high school was their highest level of education, 47% had less than a high school education, and 52% either attended or completed post-secondary education or training. Thirty-four per cent were currently unemployed, which is a much lower percentage than any other program reviewed in this study. 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[20] why they were not employed. 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 between $10,000-$14,999, with 28% earning less and 28% earning more.

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

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 a mean 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 are not representative of the entire sample. Common conditions include diabetes (30%), asthma (26%), and cancer (16%). Thirty-six per cent of the participants reported a past traumatic brain injury or head injury. Houselink did not collect information on co-morbid conditions at the 12 or 24 months data collection period.

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. As mentioned scores can range between 20 and 140, with higher scores indicating a better quality of life. At baseline, participants reported an mean QOL score of 88.8 (range 22-136, sd 26.8). The total score was also moderately positively correlated with the global measure of quality of life ($r= .590$, $p<.001$).

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. As mentioned, 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.

Pathways Calgary

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

Thirty-seven per cent of participants had been in foster care at some point during their own childhood. Nineteen per cent of participants completed high school, 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 for 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 between $15,000 and $19,999[21], 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

[21] 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.

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 participants' ability to live independently in the past, or length of time they were 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.

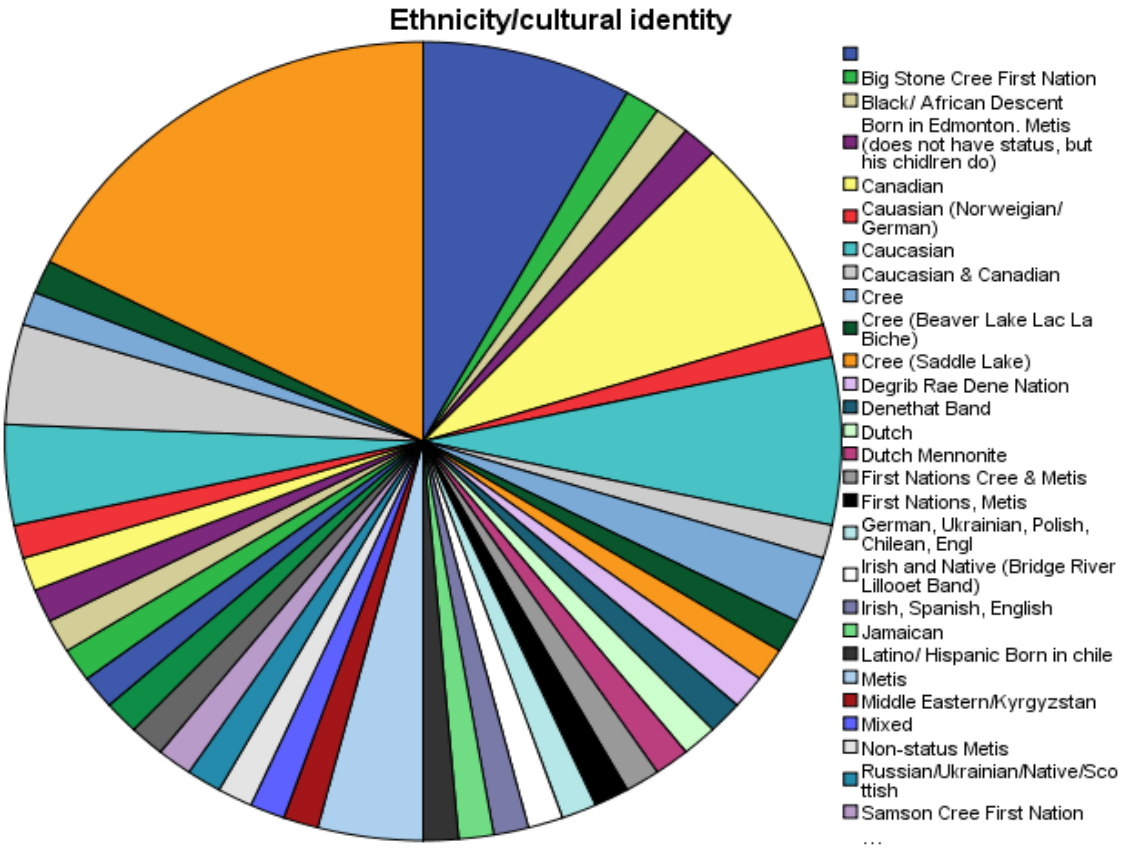
Participants reported a mean of 3.71 (range 0-13) co-morbid physical health conditions at baseline. Most frequently reported conditions include asthma (25%), hepatitis C (18%), and chronic bronchitis or emphysema (13%). Thirty-seven per cent of participants reported a past traumatic brain injury or head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

Sixty-five participants completed a questionnaire on substance use, the GAIN, at baseline. 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.

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 mean age was 43 (range 21 to 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 reported being single, 4% married or common-law, and 34% widowed, divorced, or separated. Forty-eight per cent of participants had children and 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.

Pathways Edmonton did not collect information on the educational level of its participants. The majority of participants (94%) reported that they were currently unemployed. Of these, 59% cited mental illness as the reason they were not working, 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 between $10,000 and $14,999, with 34% earning less and 7% earning more.

At study entry, common living arrangements 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 mean 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 a mean 6.10 (range 2 to 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 are not representative of the Pathways Edmonton program. 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 ($r = .603$, $p < .001$). Thus participants reported a modest quality of life which was substantiated with its relationship to a global measure of the quality of life.

Thirty-nine participants completed, the GAIN at baseline. Of these, 51% reported a history of substance use disorder in the past month, 77% in the past year, and 95% reported a lifetime history of substance use disorder.

Program Comparisons

"Housing first" models were designed to serve persons with mental illness and co-occurring addictions who are experiencing homelessness. Therefore, common in participant characteristics across programs in a "housing first" model were to be expected. Table 3, at the end of this report, provides details of 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.

Comparison of data analysis among sites and the At Home/Chez Soi study

Age

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 mean age was among the Houselink participants. This may be a artifact 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. 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 sample .

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, the reasons for this relatively even gender representation are unknown. 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 similar to At Home/Chez Soi in percentage of participants born in Canada. Only 40% of HomeBase participants responded to this question As a result, it is unclear how many participants were immigrants or refugees. More complete data comes from other programs: Results showed that 81% of Pathways Calgary and 70% of Houselink participants were born in Canada, close to At Home/Chez Soi participants (81%). Pathways Edmonton did not provide information on country of birth.

Conclusions: Given the disparate information across sites, it is difficult to arrive at a decisive conclusion. Because At Home/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

The number of Aboriginal participants varied across programs and accounted for: 35% of Pathways Edmonton; 30% of HomeBase; 13% of Pathways Calgary participants; 5% of Houselink and 22% 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. 25% of At Home/Chez Soi participants reported ethnocultural status that was not Caucasian.

Conclusion: Aboriginal people are routinely over-represented among counts of homeless persons. However, the rates reported by HomeBase (30%) and Edmonton (35%) are above norms for those cities 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, since the GTA has a large heteroculturtal population. Western areas also have a higher proportion of aboriginal people. However, the 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 and never married (96% and 80%, respectively) However, 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 and never married (68% and 62%, respectively) compared with 70% 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?"

The number of participants who are parents varied across programs: 31% of Pathways Calgary; 16% of Houselink; 48% of Pathways Edmonton; HomeBase did not collect this information. Reports of parental status may be influenced by those who only reported on their dependent children, in their care or for whom they held legal responsibility, rather than all their children (including those who are now adults) . Thirty-one per cent of At Home/Chez Soi participants were parents.

Conclusion: Contrary to public perception, many people who experience mental illnesses and addictions have had or been in close personal relationships, some of which resulted in children. These children may be in parental custody, or be able to be returned to them if the parent has secure housing. Programs housing those with a mental illness should therefore be prepared to accommodate couples and families with dependents.

Education

The two Calgary programs had high numbers 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, significant number 52%, attended or completed some post-secondary education or training. Since Houselink offers post-secondary and employment-related training opportunities, this high rate of additional education may be an artifact of the program's offerings. The educational level of participants in Pathways Edmonton were spread out: 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% had attended or completed post-secondary education or training.

Conclusion: Lack of education is a significant issue for participants in this study as rates of non-completion of high school are above those in the general population. This influences the ability to obtain vocational training and/or employment that will pay more than a minimum wage (a necessity for independent housing in the cities in this study). People who are stably housed, such as in Houselink, may have more interest in opportunities for additional education. This is an issue that requires further exploration.

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 does not appear to be 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. This may point to those with a military career as possible developing their problems during or after their military service. Again, this is an issue that requires additional research.

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, therefore 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 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. This reflects the programs inclusion of tenants in its program employment, in addition to other training opportunities available. Since 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. The discrepancies are interesting. While Calgary has the lowest vacancy rate and the

highest rental costs, it also has the lowest core housing need rate of the three cities. The current robust economic climate in Calgary likely 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.

Table 4.

Housing Availability and Affordability (2013)

	Calgary (CMA)	Edmonton (CMA)	Toronto (GTA)
Vacancy rate (2013)	1.0%	1.4%	1.6%
Core housing need[22] (% of households)	9%	10.6%	19%
Average rent (1 BR unit)	$1040	$915	$940

HomeBase and Houselink participants experience similar average longest periods of homelessness prior to entry into their respective 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 higher average period of homelessness prior to entry into the program at 66 months, or 5.5 years. Pathways Calgary did not collect this information but reported that 98% of participants were chronically homeless (at least six months of homelessness prior to program entry). Since response rates, these reported rates

[22] "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).

of length of homelessness may not represent all clients/tenants. Another difference is the extent of absolute and precarious homelessness in the programs. Like the At Home/Chez Soi project, all those admitted to the two Pathways programs and to the HomeBase program, were absolutely homeless or precariously housed on admission to the program. A careful audit of Houselink admissions (n = 341) described prior housing status on admission to the program as 66% homeless or precariously housed. When those who are relatively homeless are included, those considered homeless comprise 83% of all Houselink admissions.

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 reach individuals with the longest periods of homelessness and it appears that Edmonton and HomeBase were succesful. Houselink, which is targeted to provide supported housing to those with a history of a mental illness, has a high rate of those who are homeless or precariously housed on admission, but this rate is not as high as the other programs or the At Home/Chez Soi participants. The difference in housing status prior to program entry may impact subsequent housing stability. However, there is little literature that documents the relationship between future housing stability and a history of homelessness immediately prior to entry into a "housing first" program. What is known is that overall reported rates of lifetime homelessness prior to program admission do not vary extensively across the four programs in the present study.

Mental Health Impact 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. The extent of the disability or the duration of the illness are not formally factored into for the determination of eligibility. HomeBase has no requirements. While Houselink relied on a reported history of treatment of a mental health disorder, it does not complete a mental health assessment at intake. Both Pathways programs conduct a comprehensive psychiatric assessment as a component of their intake process. HomeBase does not do an intake assessment to screening for mental health problems. To ascertain the extent of mental health problems, 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 robust psychometric properties and can discern a clinical level of psychiatric symptoms (Boothroyd & Chen, 2008). A score of 30 or more indicates a need for intervention. The two tables below (Tables 5 and 6) provide the respective CSI scores for HomeBase and Houselink participants.

Table 5

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

Table 6

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 information using a different assessment tool, the HoNOS. The HoNOS is a widely used instrument to measure severity of mental health and addiction problems and 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. The (HoN0S?) is 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 five indicates severe to a very severe problem. A total HoNOS score can range from 0 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; and problems with occupation and activities. HoNOS scores as intake were reported in Table 7, as follows:

Table 7.

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				

Mean client 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). Thus, the clients 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 (m= 48.97, sd= 14.69). Houselink scores are higher than those for HomeBase (m= 33.56, sd = 11.18), 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 which 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, symptoms of impaired thinking may related to those conditions of brain injury and substance abuse. However, while this is a possible explanation, the data are not conclusive.

Conclusions: All three programs that measures levels of clinical mental health distress demonstrated high levels of mental health problems. Because not all programs used the

same instruments, comparisons are approximate. However, the literature reports substantive reliability for the instruments and thus these measures and their results are considered 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 in the various programs had a traumatic brain or head injury in the past. These figures are similar to those reported by At Home/Chez Soi. 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 suggests 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 among 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 an 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, and because when participant recruitment during the start-up phase of the program, high needs individuals were deliberately recruited for housing . Also, the Edmonton program staff report that self-reports of justice system involvement differ from police and emergency services reports, thus threatening the validity of responses.

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 client demographic information collected as a targeted effort at Houselink, which provided baseline information about the members/tenants. Houselink used peer interviewers in its data collection process. Thus data were not collected in the same way across all four programs, which may impact its generalizability. Data sets were also incomplete in many instances, which affected the ability to compare elements of demographics and functional challenges. Finally, not all sites utilized identical instruments, limiting cross-site comparisons. Housing retention rates were drawn from the individual programs administrative database and are reliable but not independently validated.

Summary

One of the key research questions 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 suggest some similarities and some differences in client profiles compared with those reported from the At Home/Chez Soi study, and that variations that may be due to regional differences and purposeful recruitment of selected groups in the At Home/Chez Soi study. 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[23]. Notable differences include that

[23] The site specific reports from the At Home/Chez Soi study were not available at the time that the present report was prepared.

while the At Home/Chez Soi study participants were all absolutely or relatively homeless at program entry, and all persons in the Edmonton and Calgary Pathways and HomeBase programs, but fewer Houselink tenants were absolutely homeless at program entry. The extent to which this is a significant factor that affects long-term housing retention in a "housing first" program is unknown.

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 similar to the At Home/Chez Soi cohort in certain traits such as length of homelessness (Houselink and HomeBase and marital status (Pathways Calgary and Pathways Edmonton). Other programs stand out in a specific feature such as the length of homelessness for the Pathways Edmonton cohort, their high rate of criminal justice involvement, the numbers who report that being parents, and a 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 who are currently employed or in training programs. Yet, most of Houselink's other demographic characteristics are not markedly different from the other programs of the national AHCS cohort. These higher rates (of what) may be a result of educational and employment opportunities available while member/tenants of the organization, thus this cannot be accurately compared with other programs that reported this information only on admission.

In the At Home/Chez Soi study, participants were evaluated for acuity of need, and divided into high and moderate needs groups Thirty eight percent of participants identified as high need. No such delineation occurred in the programs in this study and thus it is not possible to determine the extent to which the current participants had high or moderate needs. Demographic profiles indicate that life-time substance abuse ranged from 83% to 95% in the current programs, substantially higher than in the At Home/Chez Soi study. Similarly, criminal justice system involvement is higher in most of the programs. However, the extent to which these factors play a role in long-term housing retention in "housing first" programs is not well understood.

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

It appears that people housed in the programs in this study have substantial personal challenges and needs compared to at least the "moderate needs" group in the MHCC's study. The AHCS study indicated that participant mental health stabilized, requiring fewer emergency room and hospital visits after stable housing was achieved. This stabilization, which has also been noted by other housing first researchers, would suggest that Houslink participants, who have been stably housed, would also have a reduced need for mental health interventions. Thus the fact that they have continued high CSI scores would point to a group who continues to have persistent impairment as a result of mental illnesses. Because the issues of severity of impairment and homelessness may impact the ability to remain stably housed. While housing retention in a "housing first" program may be influenced by severity of impairment or an extensive history of prior homelessness, this relationship has not been demonstrated.

These findings underscore that "housing first" approaches are highly effective in several formats: those with ACT, ICM and a general case management approach. Critical factors in housing retention in addition to housing choice supportive services and tolerance for substance use, are organizational factors that are integrally related to program auspices, philosophy, culture and recovery orientation. They also include peer integration into program governance and operations, and the presence of a well-developed eviction prevention strategy. All of the latter factors are fundamental to the Houselink program whose retention rate is higher than any other reported program investigated here or any study of housing retention using any organizational format reported in 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 need. In this study, one finding is that a program which aims at high client retention in housing should include in addition to a "housing first" orientation:

- A strong, explicit and implicit recovery orientation woven into program activities and organizational culture
- Integration peers into program governance and 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 the use of instruments that can easily determine level of acuity of need so individuals can be assigned to ACT, ICM or CM organized services.
- Identify a unified standard for reporting housing/residential stability.
- Examine the organizational aspects of housing programs (e.g., 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 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[24]	 45 36 4 15	 59[25] 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**	 23 12 28 0 0 8	 26 12 10 0 3 15	 25 13 18 10 3 10	 38 21 52 0 5 0	 24 18 20 3 4 10

[24] Program data from a detail admissions audit indicates that 83% were homeless or precariously housed prior to admission.

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

Epilepsy/seizures **Heart disease** **Diabetes** **Cancer**	24 8 4	3 30 16	8 1 3	12 17 0	7 9 3
Traumatic Brain/Head Injury **Knocked unconscious one or more times**	60	36	37	45	66

[2]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[26]

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

[26] [26] Tsemberis (Tsemberis, 2011

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

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 and educational services. Specifically, the program: 1) has established formal & 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, 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, and 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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