FINAL CROSS-SITE REPORT ON HOUSING FIRST IMPLEMENTATION IN SIX CANADIAN COMMUNITIES

Canadian Institutes of Health Research
Partnerships for Health Systems Improvement
"Transforming Housing and Treatment Services for Chronically Homeless Persons with Mental Illness in Canada: A Systems Approach to Integrated Knowledge Translation"

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Main Messages

- A study was undertaken from 2013-16 to examine the scaling up of Housing First (HF) in six Canadian communities (Fraser, BC, Saskatoon, SK, Winnipeg, MB, Waterloo and York Regions, ON, and Halifax, NS).
- The study used two theoretical frameworks to understand the scaling up process:
  (a) the Interactive Systems Framework of knowledge translation, which includes three systems: knowledge synthesis and translation (e.g., the HF toolkit, video materials), the support system (e.g., HF training and technical assistance), and the delivery system (e.g., community entities that provide HF programs), and
  (b) a stage-based model from implementation science that views implementation as moving from exploration to installation to active implementation.
- The research coincided with a change in federal policy of its Homelessness Partnering Strategy (HPS), in which HPS funds were shifted to HF programs in 61 Canadian communities.
- A HF training needs assessment conducted at the beginning of the project revealed that community stakeholders desired training on issues such as the principles of HF, how to implement HF, and how to engage with landlords.
- The Pathways HF training and technical assistance (TTA) team funded by the Mental Health Commission of Canada conducted initial and follow-up training on-site, with each training lasting at least 2 days, and regular conference calls with community stakeholders to advance HF implementation.
- In the 6 communities in this study, 14 new HF programs were created, and 9 HF programs were sustained or enhanced over the course of the study period.
- All of the new programs had moved through the exploration and installation stages to achieve initial or full implementation after 3 years.
- Fidelity assessments were conducted with 10 of the 23 HF programs and the average fidelity score across programs and fidelity domains was 3.3/4, which compares favourably with fidelity ratings of the high fidelity programs implemented for the At Home / Chez Soi research demonstration project programs.
- There was some evidence of systems transformation in terms of (a) changing the mindsets of local stakeholders about HF and homelessness, (b) coordination, collaboration, and capacity development around community homeless services, and, to a lesser extent, (c) policy changes.
- Community stakeholders reported different facilitators and barriers to HF implementation at different stages: exploration, installation and implementation. For example, community resistance was a common barrier during the initial exploration stage, but accessing resources was a more prominent barrier during the installation stage; local champions were important facilitators, in both exploration and installation phases; and congruent policy played a role (both hindering and helping) through all stages.
- Regional training, regional community of practice teleconferences, and regional network development occurred in Western Canada, the Prairies, Ontario, and Atlantic Canada.
- Inspired by Alberta's 7 Cities network, new HF networks have emerged in BC and Ontario to enhance HF implementation and mutual learning and collaboration among network members.

Executive Summary

Overview

This report summarizes findings from a study conducted from 2013-16 of expanding Housing First (HF) in six Canadian communities: Fraser Valley, BC, Saskatoon, SK, Winnipeg, MB, Waterloo and York Regions, ON, and Halifax, NS. This research project, "Transforming Housing and Treatment Services for Chronically Homeless Persons with Mental Illness in Canada: A Systems Approach to Integrated Knowledge Translation," was funded through the Canadian Institutes of Health Research's (CIHR) Partnerships for Health Systems Improvement (PHSI) program. The aim of this PHSI project was to examine the implementation of HF in the six communities, through training and technical assistance (TTA) and networking, supported by the Mental Health Commission of Canada (MHCC). Following the success of MHCC's At Home / Chez Soi research demonstration project, MHCC strived to expand the HF approach to new Canadian communities, as well as sustaining and enhancing existing HF programs.

Methodology

This cross-site case study is based on an analysis of data collected from September, 2013 to September, 2016 through: (a) training needs assessment focus groups (k=11, n=83), (b) TTA workshop evaluations, initial (n=302) and follow-up (n=154), at each site, and TTA workshop evaluations in four regions of Canada (n=276), (c) fidelity assessments of HF programs (k=10), (d) focus groups and individual interviews with stakeholders during 2016 at the end of the project (k=7, n=35), and (e) field notes (tracking forms) on meetings and conversations between PHSI researchers, MHCC TTA staff, and local and regional stakeholders (n=146).

Knowledge Translation and Implementation Framework

The study used two theoretical frameworks to understand HF implementation. First, the Interactive Systems Framework of knowledge translation was used (Wandersman et al., 2008). This framework includes three systems: (a) the *knowledge synthesis and translation system* that includes information conveyed in plain language (e.g., the Canadian HF toolkit, video materials), (b) the *support system* designed to provide TTA to local stakeholders in the HF approach, and (c) the *delivery system* that consists of community stakeholders who plan and implement HF (e.g., community entities of HPS that fund HF programs).

Second, Fixsen et al. (2010) have proposed a stage-based model for implementation. An assessment of needs, feasibility, fit, and requirements occurs during *exploration*, while communities establish the foundations for implementation within relevant settings and systems (e.g., financial, physical space, hiring staff) during *installation*. In *initial implementation*, the innovation is put into practice with a focus on promoting continuous improvement, evaluation, and problem-solving, while *full implementation* occurs once actual innovation practice moves towards ideal model fidelity, and the innovation has been integrated within the community.

Federal Homelessness Policy Context

The research coincided with a change in federal policy of its Homelessness Partnering Strategy (HPS). In 2013, based in part on the At Home / Chez Soi findings, the federal government

announced major changes to its funding for homelessness programs to 61 Canadian communities. Beginning in 2015, HPS mandated the reallocation of HPS funding to a HF approach in 61 Canadian communities.

Patterns and Variations in the Service Landscapes of the Six Communities

The service delivery landscape in participating communities involved numerous stakeholders. In communities where significant activity occurred prior to the HPS policy shift, convening bodies such as United Way and Municipal Task Forces were involved. Once the HPS policy shift occurred, the HPS Community Entities (CEs) and Community Advisory Boards (CABs) played an increasingly central role, administering and allocating federal homelessness funding in accordance with a 5-year Community Plan. The Community Plan was intended to complement the efforts of other stakeholders at municipal, regional, and provincial levels.

Training and Technical Assistance

A HF training needs assessment conducted at the beginning of the PHSI project revealed that community stakeholders desired, or identified a need for training on issues such as the principles of HF, how to implement HF, and how to engage with landlords. The HF TTA team from MHCC conducted initial and one or more follow-up trainings on-site, with each training lasting at least 2 days. The initial training workshops were held during the *exploration* and *installation* stages of implementation, were aimed at a broad range of stakeholders, and focused on HF principles and practices. The second training workshops occurred during *initial* or *full implementation*, were aimed primarily at HF staff, and focused more on skill-building and case consultation. Participants rated the HF initial and follow-up training workshops very positively with average ratings of 4.0/5 for comprehensiveness of and satisfaction with the workshops. As well, regular conference calls with TTA staff, PHSI researchers and community stakeholders were scheduled to advance HF implementation.

Implementation Outcomes

New, sustained, and enhanced programs. In the 6 communities, 14 new HF programs were created, and 9 HF programs were sustained or enhanced over the course of the study. Furthermore, all of the new programs had moved through the *exploration* and *installation* stages to achieve *initial* or *full implementation* after 3 years. In the two largest communities (Fraser and Winnipeg), several new HF programs were created, including programs that were adapted for specific populations (e.g., LGBTQ youth, Aboriginal people, women).

Fidelity. A fidelity assessment provides an estimate of how closely a program adheres to the core domains of the Pathways HF model. Fidelity assessments were conducted with 10 of the 23 HF programs and the average fidelity score across programs and fidelity domains was 3.3/4, which compares favourably with fidelity ratings of the At Home / Chez Soi research demonstration project programs. The highest fidelity scores were obtained on the domain of Separation of Housing and Services, while the lowest scores were obtained for the Service Array domain.

Systems transformation. There were three themes regarding systems transformation. First, participants spoke of the HF TTA helping to change the mindsets of local stakeholders about HF and homelessness. For example, there was some indication that local stakeholders had shifted from a "treatment first" to a "housing first" orientation. Second, there was evidence

of increased coordination, collaboration, and capacity development with local stakeholders coming together to plan HF programs. Third, policy changes were thought to both precede and enhance the development of HF programs, and to result from experience with HF.

Barriers and Facilitators to HF Implementation

Community stakeholders experienced different barriers and facilitators to implementation of HF at different stages. In the *exploration* stage, the main barriers were community concerns, challenges framing problems and solutions, lack of planning alignment, and a lack of working relationships, particularly between housing and mental health. Facilitators included readiness (i.e., previous HF experience) and champions who convened relevant players and created alignment around a clear vision. Timing was also an important factor as it could take time for key players to devote attention and resources to the issue, and for coalition members to move into alignment. Inadequate resources were barriers in the *installation* phase, particularly around housing subsidies. Champions who could span system boundaries and draw mental health support was a key facilitator, as was selecting an appropriate lead agency with an organizational culture that was conducive to HF practice and values. In the *initial* and *full implementation* phases, key barriers related to limitations on housing choice, rehousing, service array, and systemic issues. Facilitators included access to rent supplements, becoming proactive and preventive around housing and recovery, and reflective practice to build and adapt programs to meet local needs and values.

HF Regional Networks

Regional training, regional community of practice teleconferences, and regional network development occurred in Western Canada, the Prairies, Ontario, and Atlantic Canada. Inspired by Alberta's 7 Cities network, new HF networks have emerged in BC and Ontario to enhance HF implementation and mutual learning and collaboration among network members.

Conclusion

This study demonstrated that, over time, 6 communities were successful in implementing new and/or enhanced HF programs. Through changes in federal homelessness policy and funding, TTA, and regional networks, diverse communities were able to overcome implementation barriers and facilitate the implementation of relatively high fidelity HF programs. Given the limitations in existing resources, communities exhibited strong leadership and innovation in achieving such high-fidelity implementation of the HF approach that required a "sea change" in mandate and the way resources were allocated in communities. Throughout the change process, community champions played an integral role in moving implementation forward in this new context. Similarly, the TTA provided strong support, particularly with programmatic aspects of HF implementation. Moving forward, communities need continued implementation support with systemic issues, such as coordinated entry and guidance around effective prioritization assessment tools that are appropriate for identifying persons experiencing chronic homelessness. Communities also require attention to issues of HF program sustainability. Through evaluation, some participating communities have begun to demonstrate improved participant outcomes. By continuing to demonstrate improved outcomes, communities can solidify and build their programs for the future.

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Background

Overview

Funded by Health Canada and sponsored by the Mental Health Commission of Canada (MHCC) from 2008-2013, At Home / Chez Soi was a five-city research demonstration project that evaluated the effectiveness of the Housing First (HF) approach to ending homelessness among people with lived experience of mental illness and homelessness (Goering et al., 2014). HF is an approach that is based on the principles of consumer choice, community integration, and recovery (Tsemberis, 2015). The two key components of HF are housing and support. Rent subsidies are provided so that consumers access rental market housing in their respective communities. Moreover, housing is permanent and rapidly provided. The support component typically consists of Assertive Community Treatment (ACT) or Intensive Case Management (ICM). ACT is a "wrap around" approach that is provided by a multi-disciplinary mental health team that is available around the clock. ICM is provided by a team of individual case managers who broker many of the services for consumers, and case managers are typically available during the day only.

The At Home / Chez Soi research demonstrated that HF successfully ended homelessness for the majority of project participants, as well as promoting positive psychosocial outcomes. Following the conclusion of At Home / Chez Soi, the federal government renewed and repurposed its Homelessness Partnering Strategy (HPS) program that funds homelessness initiatives in 61 Canadian communities. The new mandate of HPS was to reorient existing approaches to the HF model (Macnaughton, Nelson, Goering, & Piat, in press). To assist communities in making this transition, the MHCC implemented a HF Training and Technical Assistance (TTA) initiative from 2014-2016. The TTA provided support to 18 Canadian communities striving to implement the HF approach.

Also from 2014-2016, the *Transforming Treatment Services and Housing for People with Mental Illness in Canada: A Systems Approach to Integrated Knowledge Translation* research project was funded through the Canadian Institutes of Health Research's (CIHR) Partnerships for Health Systems Improvement (PHSI) program. This project examined the processes and impacts of six of the 18 communities that received TTA from the MHCC program. The six project communities were selected prior to the initiation of the TTA program. Some of the communities had already approach MHCC for guidance in developing HF programs. The researchers aimed to select communities from across Canada. This report synthesizes findings from case studies of the implementation of HF in the following six Canadian communities: Fraser Valley, BC, Saskatoon, SK, Winnipeg, MB, Waterloo, ON, Toronto/York Region, ON, and Halifax, NS. Two other cities, Montreal and Toronto, were approached to participate in the PHSI research and TTA, but neither the research nor the TTA were able to take root in these cities. We say more about this later in the report.

Research Questions

The specific research questions that were addressed are:

1. What is the story of the HF implementation process at the sites?

2. How does TTA contribute to HF implementation?

3. What are the outcomes of the HF implementation process?

4. What factors facilitate or impede HF implementation?

5. How do regional training and regional networks contribute to HF implementation?

Methodology

This cross-site case study is based on an analysis of data collected from September, 2013 to September, 2016 through: (a) training needs assessment focus groups conducted in each of the communities (k=11, n=83), (b) initial (n=302) and follow-up (n=154) TTA workshop evaluations in each community, as well TTA workshops conducted in four regions of Canada (n=276), (c) fidelity assessments of HF programs (k=10), (d) focus groups and interviews with stakeholders during 2016 at the end of the project (k=7, n=35), and (e) field notes (tracking forms) on meetings and conversations between PHSI researchers, MHCC TTA staff, and local and regional stakeholders (n=146). Five members of the research team liaised with the communities, attending site and regional training events, participating in conference calls, and collecting data. More information about the different sources of data collection is provided in Appendix A, and the protocols for data-gathering are provided in Appendix B. The focus group, individual interviews, and the field notes were all qualitative data. The workshop evaluations included both qualitative data and some numerical rating data.

The fidelity assessments yielded quantitative data, as well as narratives about each program's fidelity. The Pathways Housing First Fidelity Scale (Stefancic, Tsemberis, Messeri, Drake, & Goering, 2013) was used to assess program implementation along 38 items within five broader domains (Housing Choice and Structure, Separation of Housing and Services, Service Philosophy, Service Array, and Program Structure). Fidelity assessments of each HF program were conducted by a Quality Assurance team consisting of TTA trainers and PHSI researchers. Because the programs used two different models of service delivery that varied in intensity, two versions of the Pathways Housing First Fidelity Scale were developed – one for ACT teams and one for ICM teams. There was a great deal of overlap between these two versions with the most noticeable difference that ACT teams were assessed on the degree to which they directly provided an array of services, whereas ICM teams were assessed on the degree to which they were able to broker these same services. Each of the 38 items was rated by the Quality Assurance team on a 4-point scale (with a high score indicating a high level of fidelity), and each item was benchmarked. This fidelity measure has been found to have good psychometric properties (Nelson et al., 2014), and it has been shown to be directly related to positive outcomes for HF participants (Goering et al., 2016). Additionally, a parallel fidelity self-assessment measure was used with three of the programs (Gilmer, Stefancic, Sklar, & Tsemberis, 2013).

The fidelity assessment consisted of a full-day site visit to each program and included program meeting observations, staff interviews, consumer chart reviews, and a consumer focus group. Approximately 6-12 staff were interviewed at each program and interviewees included

specialized frontline staff (e.g., substance use specialist), general service providers/clinicians (e.g., case manager), management staff (e.g., team leader), and members of the local housing team. Interviews were semi-structured and lasted approximately 45 minutes, with the interviewers taking notes. The consumer focus groups lasted approximately one hour with 8-12 participants. For the chart review, the Quality Assurance team reviewed a random sample of 10 charts, including progress notes for the past month as well as most recent treatment plan and assessments.

This cross-site final report is based on a synthesis of site case study reports that were prepared for each of the six PHSI communities. Site case study reports were prepared by the PHSI research team members who were responsible for the sites. The site case studies provided data for each of the research questions. This cross-site case study report was prepared using an iterative analysis and synthesis of the site case studies, that involved repeated readings of the individual reports, and concurrent reflective writing/rewriting to generate a cross-site analysis and synthesis.

A draft of this final report was circulated among the core group of PHSI researchers, decision-maker partners, and site stakeholders in each of the PHSI communities to obtain their feedback. Feedback on the draft report was incorporated into the final report.

Knowledge Translation and Implementation Framework

This project incorporates two complementary theories as a way to conceptualize the process of knowledge translation and implementation. These included the Interactive Systems Framework, and a stage-based approach to the implementation process.

First, the Interactive Systems Framework (ISF) (Wandersman et al., 2008) was adopted as the knowledge translation framework for this study. The ISF is a widely-applied model of interactive knowledge translation in community settings. The framework consists of three inter-related systems: (a) the synthesis and translation system, (b) the support system, and (c) the delivery system. In the *synthesis and translation system*, information is shared through accessible and relevant resources and materials. The PHSI project builds upon the findings of the At Home / Chez Soi research project and shares the knowledge gained from that project through circulation of the HF Toolkit and various interactive strategies such as workshop presentations and facilitated discussion. In the *support system*, researchers work with communities to develop innovation-specific capacity. This capacity is developed through strategies such as ongoing sharing of resources, TTA, and quality assurance (Wandersman et al., 2012) and peer networking and incentives (Leeman et al., 2008). The support system in the PHSI project involves a TTA team that shares knowledge about HF with partnering communities. This team provides TTA through the activities such as on-site training, follow-up support, webinars, communities of practice, and regional events. The *delivery system* consists of the stakeholders who are actively involved in planning and delivering a new program or initiative. In the PHSI project, the delivery system is comprised of HPS communities that are partners in this project and are actively developing local strategies for HF implementation. Through the application of the framework, researchers aim to assist communities to build knowledge about HF and how to implement HF successfully (innovation-specific capacity) and to develop the leadership capacity, resources, and buy-in necessary to facilitate change in their communities (general capacity) (Wandersman et al., 2008).

Previous research suggests that the effective implementation of innovations involves a series of stages or phases that encompass a set of key activities. Several stage-based models of implementation have been proposed (e.g., Chamberlain, Brown, & Saldana, 2011; Fixsen et al., 2010; Meyers, Durlak & Wandersman, 2012), which recognize that the processes of implementation are not linear or discrete, but rather iterative and contextual. Fixsen et al.'s (2010) model has been used extensively in implementation research, and identifies four main implementation stages: (a) *exploration*, during which users (particularly implementation champions and leaders) assess needs, feasibility, fit, and requirements (e.g., core components) of an intervention; (b) *installation*, during which communities establish the structural and instrumental foundations for implementation within relevant settings and systems (e.g., financial resources, physical space, technology, human capital, referral pathways, and competencies); (c) *initial implementation*, in which the innovation is put into practice with a focus on promoting continuous improvement, evaluation, and problem solving, with particular attention to implementation drivers; and (d) *full implementation,* which occurs once the innovation has been implemented with reasonable fidelity, and been integrated and standardized within a setting or community.

Context

The Federal Homelessness Policy Context

The PHSI project was conceived prior to a major shift in federal homelessness policy. The initial intent of the PHSI project was to examine and support the dissemination and implementation of HF, as an extension of the At Home / Chez Soi project. As was indicated earlier, due to the successful results of the At Home / Chez Soi project, in March 2013, the federal government announced its new policy mandate for HPS, which involved a shift in funding to the HF approach. Specially, for the 10 largest Canadian communities, 65% of their federal HPS funding was to be reallocated to HF, while in 51 mid- to small-sized communities, 40% of their HPS funding was to be devoted to HF. HPS funding comprises a relatively small portion of overall funding for homelessness service delivery, which features multiple sectors (health, housing, justice) and levels of government (municipal/regional, provincial, federal). While the federal share constitutes a relatively small portion, this shift was viewed as a catalyst to funding shifts towards HF at the provincial and municipal/regional levels. The timing of the HPS policy shift meant that the PHSI research started at the point when this window of opportunity opened for participating communities to embark on HF implementation.

Communities

Mental Health Commission of Canada training and technical assistance communities. Given the strength of the At Home / Chez Soi findings and the shift in HPS mandate, the MHCC initiated a program to provide the TTA initiative, which provided support to 18 communities. Pathways to Housing was contracted to deliver the TTA in collaboration with a team of former staff and people with lived experience from At Home / Chez Soi teams who were recruited as experts to complement the Pathways training using a "train-the-trainer" approach.

Research communities. Six communities were involved in the PHSI initiative from different geographic regions and having diverse community characteristics from the standpoint of population size and composition. The communities include: the Fraser Health geographical

area in Metropolitan Vancouver (specifically, Surrey, Mission, Abbotsford, and the New Westminster/Tri-Cities area, British Columbia); Saskatoon, Saskatchewan; Winnipeg, Manitoba; the Regional Municipality of Waterloo, Ontario; York Region (in the Greater Toronto Area); and Halifax, Nova Scotia. Collectively, these comprise a range of community types, including metropolitan (Winnipeg, Halifax), suburban (York Region, Fraser), and growing mid-size cities (Saskatoon and Waterloo Region, which includes Kitchener, Waterloo and Cambridge). The project sites also span Canada's geographical regions, including the West Coast, the Prairies, Ontario, and Atlantic Canada. The project sites feature cultural diversity, with communities where Aboriginal people are prominent and constitute the majority of people experiencing homelessness (i.e., Saskatoon, Winnipeg).

While the PHSI team endeavored to develop partnerships with communities that were motivated to implement HF at the outset of the project, all of the communities were at different stages in the process, and operated within different implementation climates.

Patterns and Variations in the Service Landscape

The service delivery landscape in participating communities involves numerous players, sectors, and funders. In each community, the homelessness sector provides shelters, drop-in services, outreach, as well as providing or brokering more permanent supportive housing to previous shelter users. In some communities, the local health authority plays a role, by supporting previously homeless individuals with ACT teams, and/or by providing housing, either directly, or by contracting with non-governmental (NGO) or community-based organizations (CBO). In some communities, the NGO/CBO sector also plays a prominent support role. In other sites, inner-city community health clinics host support teams for previously homeless individuals.

In addition, provincial, municipal, and regional governments play a service delivery role in each of the participating communities, providing social and supportive housing to people with mental illness and who may be homeless or considered "at-risk of homelessness." In the Ontario communities, the municipality or region plays the role of service manager for both housing and homelessness and also has a direct service role in the provision of affordable housing. As discussed further below, in most of the communities, the municipal government plays a planning and/or convening role. Finally, in one of the communities (Winnipeg), HF programs were established as part of the At Home / Chez Soi demonstration project. Although these programs have changed and have experienced sustainability challenges, in some form, they continue to contribute to the existing service delivery landscape.

Housing First Implementation

Question 1 – What Is the Housing First Implementation Story?

In this section, we discuss the key stakeholders across the six communities, and implementation activities undertaken in each community. In so doing, we provide a short summary of the HF implementation stories.

Key stakeholders and their respective roles. There are a number of stakeholders that played significant roles in HF implementation, both before and after the HPS policy shift. Below we describe these players and their respective roles, which could be characterized as pre-HPS

convenors, post-HPS leaders, and other stakeholders that played a complementary role both prior to and following the HPS policy shift.

Pre-HPS planning convenors and champions. In the communities where significant activity occurred prior to the HPS policy shift, this was generally facilitated by a convening body, an organization that generally stood outside the service delivery system, but possessed credibility as a neutral player, that was able to dedicate some resources and leadership, and bring key stakeholders together. These convenors created the conditions for dialogue, planning and strategy development amongst the various community partners, including those who played a more direct role in the housing stability and homelessness sector, as well as other key players, such as mental health, addictions, law enforcement, and grassroots community organizations. The main examples here were municipal/regional governments (Fraser, Winnipeg, Waterloo, York), health authorities (Fraser, Winnipeg, Halifax), philanthropic organizations; the United Way (Saskatoon, Winnipeg, York, Halifax), City Task Forces (Fraser, Saskatoon, Winnipeg), and housing organizations (Halifax).

Post-HPS convenors and champions. Once the HPS policy shift occurred, the HPS Community Advisory Boards (CABs) and Community Entities (CEs) played an increasingly central role in local HF planning in all communities, given the new HPS federal policy mandate of shifting funding to the HF approach. The role of the CE is to administer and allocate federal HPS funding. The CE role is played by various agencies in different communities, including local chapters of the United Way, municipal/regional governments, and community-based organizations with a focus on housing.

Historically, funding decisions were made using a community consensus process in accordance with a five-year plan developed or endorsed by the CAB. CAB membership is comprised of the majority of local homeless and housing service providers. In most communities, the largest portion of HPS funding was allocated to development of building projects for the target population.

It must also be acknowledged that that the larger social service culture played a significant role. After At Home / Chez Soi, the idea that chronic homelessness for people with complex needs can actually be ended was no longer just an idea or an advocacy position; it was a reality grounded in research evidence. Plans to end homelessness had new meaning and communities organized around this goal. In this larger context, the new HPS policy and funding shift was a welcome new support, an invaluable resource, and a tremendous implementation facilitator that was used to essentially "jump start" the implementation of HF programs with the goal of ending of chronic homelessness.

One final implication of the HPS funding is that in every community, it was a relative small part of the total local homeless services budget. Thus, HPS funds could only pay for a component of a HF program (e.g., some of the case management program or a portion of rent supplements). Fortunately, the HPS funding was somewhat flexible and could be utilized in creative ways to supplement other resources. However, in all cases implementation of HF programs required community partnerships and collaboration from numerous agencies. This type of composite or mosaic construction of HF programs also had implications for program operation and program fidelity.

Complementary policy players. As mentioned above, the role of the CAB and CE was to create updated Community Plans that reflected an HF focus. The intent underlying the plan was not only to guide direct federal homelessness prevention funding allocations, but to create a plan that complemented the efforts of other stakeholders. These include provincial housing ministries/authorities, health authorities, associations of service provider groups, and At Home / Chez Soi program leaders, all of which played a complementary role both prior to and after the HPS policy shift. As described below, these stakeholders generally played a support role, but in some cases continued to play a leading role. Also as discussed below, a significant challenge in the HF planning stage was to coordinate the efforts of all the various partners, including the pre and post-HPS planning convenors, and the complementary partners just mentioned.

Implementation activities in the six communities. The story of implementation across the various sites followed a similar pattern, albeit with sometimes significant variations, and was related to a number of factors. Below, we look at the story of each community, considering the: impetus for change, emerging leadership towards convening/mobilizing towards a solution, identification of lead service agencies, partnership development/resource procurement, and program implementation and growth.

Fraser. In the Fraser Health geographical region, the impetus for change came originally out of a Regional Plan to End Homelessness, which identified that homelessness was no longer exclusively a phenomenon of the urban core of Vancouver. This report also identified HF as a solution, establishing a policy climate that led to a growing awareness of what the HF model entailed. Subsequently, the City of Surrey established a Task Force on Homelessness that convened a number of players, including the Fraser Health Authority, which initially took on the lead role for implementing HF. The Fraser Health Authority provided a number of housing subsidies for ACT team clients who had issues with housing stability, and worked with the Mental Patients' Association (MPA) to procure housing stock and administer the subsidies. Initially two of the Health Authority ACT teams began practicing HF ACT with their clients who had subsidies. As the PHSI project proceeded, two recently formed ACT teams from other areas within Fraser Health also became part of the initiative, and began practicing HF ACT. As HPS funding became available, a number of new HF ICM teams were formed, which are now actively providing housing and support. An attempt was made by the CE to allocate funding in a way that built upon the previous work done within the Health Authority. Attention has now turned towards establishing a more coordinated approach within the region, and moving towards a HF system of care. Given the early success of the ACT teams in practicing HF, each of the teams has secured additional housing subsidies so as to be able to provide both housing and support to more clients, and to expand access to people with serious mental health problems and addictions who were living on the street.

Saskatoon. In Saskatoon, the impetus for change came out of a Commission that was initially formed to address panhandling and street crime, which then evolved to look at the "root causes" of these issues, in particular homelessness, mental illness, and addictions. Community leaders subsequently learned of the successful efforts being made in Alberta and within the At Home / Chez Soi initiative to implement HF, and forged a consensus that the HF model was a part of the solution. Through the leadership and resources of the local United Way, the community developed a Plan to End Homelessness (P2EH), the centerpiece of which was to develop a HF program for the 23 individuals who were most street-involved and used a high proportion of police, hospital and other acute care resources. As HPS funding for HF became

available, the CAB and CE eventually aligned their planning with the P2EH, and funded agencies to complement the HF team, including Rapid Rehousing, and HF specific to Indigenous people and youth. Through funding from the CE (of a coordinated entry system) and through the efforts of the Journey Home team, the new HF program, the community is also moving towards practicing as a "virtual team." Given the early success of the Journey Home team, there are ongoing efforts to expand the capacity of the program to address unmet needs.

Winnipeg. At the outset of the PHSI project, there was some readiness to build on the success of the At Home / Chez Soi project and to sustain the three teams that had been implemented. Given the release of the City's Plan to End Homelessness report, there was also a supportive policy climate for the HF model. However, there was uncertainty around continuation of funding, and about how the new HPS HF funds should be directed. After a hiatus, during which the community collectively learned more about HF and the new HPS mandate for the CE, key leaders, including the newly formed End Homelessness Winnipeg, the province, the Winnipeg Regional Health Authority (WRHA), and At Home / Chez Soi leadership, came together and made an implementation plan. Through HPS and the provincial and regional health authorities, the three At Home / Chez Soi teams were sustained. New HPS funding was directed towards a number of new HF teams. At the same time, the community established the groundwork for a coordinated system of care, by forming the Doorways project that provides assessment and referral to the various programs.

Waterloo. In Waterloo Region, the closure of a church-run shelter and an organizational change effort lead by the regional government to rationalize its housing and homelessness services provided the initial impetus to raise the profile of homelessness in the community. This profile was raised further when Waterloo Region became the first community to join the 20,000 Homes campaign. This occurred as the PHSI project began its operations, bringing in the Waterloo Region's STEP Home (Support to End Persistent Homelessness) program, as well as the supportive housing programs run by a local mental health housing organization. The housing and support provided by STEP Home was facilitated by the Region's funding of a number of housing subsidies, which have expanded in number due to the success of the initial pilot. The community is also exploring ways for the formal mental health housing programs to work more closely with the Region's program, through the creation of a system for common access to HF programs.

York Region. In York Region, the Local Health Integration Network (LHIN) explored HF as an approach towards a newly funded supportive housing program run as a partnership by two branches of the Canadian Mental Health Association. At the same time, as the HPS funding became available, the new CE, which moved from York Region to the United Way, also expressed interest in HF. Through the PHSI project, the CE was able to learn about HF and to identify the resources, through a multi-agency partnership, needed to implement a HF pilot, at the same time making a commitment to evaluate its initial success. Given the suburban context, and an overall lack of apartment rental stock, a focus of this site has been in developing creative ways to procure housing. Another focus is to explore greater coordination between these two HF initiatives.

Halifax. Just prior to the start of PHSI research, and in response to the new HPS mandate, a local convening agency, Affordable Housing Association of Nova Scotia (AHANS), hosted a conference on HF. Despite some previous support, there was some resistance to the HF

model articulated at this conference. At the same time, it was unclear to the community leaders how to procure the resources to build a comprehensive HF team that included housing subsidies and the requisite mental health and addictions support. Despite some initial interest in "coming to the table," the health authority was going through a reorganization process. Another agency that had been identified informally as a potential lead agency was also not organizationally ready to take on responsibility for implementing HF. After a lengthy planning process and successful efforts to secure housing subsidies, different stakeholders (AHANS, the United Way, and Health) came to lead the implementation of HF in Halifax.

Summary. The overall story of HF implementation across the six communities began with some impetus for change, arising internally, from within the community, externally because of the HF policy and funding mandate, or a combination of both of these influences. Seizing on this momentum, community leaders brought key players around the table to establish the common vision necessary to move forward, helping bridge differences in perspectives when necessary and helping disparate planning processes to align, so they could set the stage for a coordinated approach to implementation. Moving towards active implementation, the communities brought the elements, housing and support, together for implementing HF. Selecting a lead organization to deliver the HF model was the next step on the journey, which entailed finding an agency with expertise and congruent values. With the requisite financial and human resources in place, communities were then ready to bring people off the street into their own homes. As we describe below, successfully moving through the implementation stages of exploration, installation and active implementation involved a "synergy" of a number of forces coming together, including readiness, the HPS mandate (and its resources), the implementation support provided by the TTA program and the PHSI project, and the leadership within each community.

Question 2 – How Does Training and Technical Assistance Contribute to Housing First Implementation?

In this section, we discuss the types of evidence-based TTA that has occurred during HF planning and early implementation, and their influence on the implementation process. Since the beginning of the PHSI project, communities have undertaken various capacity-building activities that utilize different approaches with varying aims, including activities driven by the MHCC and PHSI, At Home / Chez Soi teams, people with lived experience, OrgCode (a homelessness services consulting firm), as well as using the Canadian HF Toolkit. The PHSI project has been broad and inclusive, and has evolved over time by using an integrated feedback process resulting in flexible approach that has influenced HF planning and early implementation.

The shift in the HPS mandate raised the urgency of HF training, buttressed by HPS funding allowances for "HF readiness" (i.e., implementation support). Anxious to respond to the requirements of the new mandate, communities pooled resources, developed new partnerships and sought TTA from several consultants that were poised to respond to community needs and respond to the consulting market created by the urgency for implementation. It is worth noting that consultation provided by Pathways to Housing and access to the Canadian Housing First Toolkit was funded through a contract from MHCC and provided without any cost to communities. Other organizations also providing consultation were paid by the community for their services.

The numerous consulting groups were not always aligned in their expert advice about how best to address the mandates of the new HPS policy. The variation in the advice and TTA provided by different consultants resulted in communities receiving a variety of messages about the HF program model. The differences in advice in some instances resulted in some confusion about the implementation and operation of the HF model that needed to be resolved.

Training needs assessment. The PHSI's capacity building efforts began with a TTA needs assessment based on focus groups and individual interviews conducted across six of the original PHSI sites (no needs assessment was conducted in York Region because it came into the project later in the process). A detailed list of themes has been compiled in another report (Hasford, 2014). It was clear across communities that stakeholders believed that TTA would be useful for addressing HF implementation needs. Although there were several differences in expressed TTA needs between sites due to variations in implementation stage, local context, and priorities, there were many broad areas of common interest. The most critical TTA needs across sites included:

- HF principles and fidelity: Clarification of HF principles, especially choice; the question of whether HF is synonymous with scattered-site housing, and the concern that scattered-site housing would be a poor fit for many clients; clarification of the extent to which the model can be adapted to local circumstances and individual client needs.

- Implementation logistics: Most communities requested TTA about the "nuts and bolts" of implementation, including concrete steps and procedures required to implement a HF program, including budgeting, managing rent supplements, coordinating teams, housing placement, etc.

- Management of support services: The management of clinical and housing supports was a critical need, given its centrality to the HF service model. Of particular interest was the need for better understanding of the coordination of clinical services and housing supports, options for staffing structures and roles for HF ACT and ICM teams, team leadership, and working collaboratively with various providers.

- Intake assessment and coordination: TTA in intake assessment to determine client acuity and suitability was an identified need in most communities. Although client screening is not a principle of the Pathways HF model, it remained a relevant concern amongst stakeholders. Several communities anticipated a need for future technical assistance with the development of coordinated intake systems, and with the implementation of a system of care aligned with HF principles.

- Clinical training: TTA in the delivery of clinical services for frontline staff was a clearly defined need across most communities. There was particular interest in the application of harm reduction or recovery-oriented approaches in the HF context, as well as how to deal with complexity and with issues with daily living. In some communities (i.e., Winnipeg and Saskatoon), a need for training in cultural competence with Aboriginal clients was identified.

- Landlord engagement: Effective strategies for recruiting and working with landlords were an important training need. Many emphasized the importance of educating landlords in mental health and harm reduction to address stigma and to promote collaboration in eviction prevention and recovery. There were notable concerns about "selling" the HF concept, negotiating housing agreements, and ensuring responsiveness in addressing crises such as property damage and active or disruptive substance use.

In Saskatoon and Fraser Valley, where implementation was ahead of the other communities, partners indicated that "flow through" (maintenance of housing stability for people who no longer need ACT or ICM services) was an emerging TTA need.

Initial training. All six of the PHSI communities received HF training delivered by Pathways to Housing through the MHCC. This consisted generally of a two-day process, with one day dedicated to facilitated planning with a small group of decision-makers (e.g., conveners, policy-makers, etc.), and another day that provided an introduction to HF philosophy and practices ("HF 101") that was targeted primarily to service-providers. In several PHSI communities (Halifax, Saskatoon, York), the decision-maker session played a significant role in HF planning, as it brought together key decision-makers and helped to formulate a shared vision and secure commitments for implementation.

Montreal and Toronto were the only sites that did not accept the offer of PHSI/MHCC training. In Montreal, this was due to lingering concerns about the MHCCs approach to At Home / Chez Soi and a desire to distance the province from the At Home / Chez Soi "brand." There was a belief that there was adequate local expertise to meet the training needs. Indeed, during the early implementation and expansion phases, At Home / Chez Soi staff provided a range of clinically-relevant training to local ICM teams. Stakeholders in Toronto showed little interest in additional training, since there were several organizations with pre-existing supportive housing programs that provided single-site support or scattered-site support, though not always with rent supplements.

Evaluations from the workshops[1] suggest that they may have had an impact on HF planning and implementation by increasing awareness and knowledge of HF, and increasing HF readiness (see Table 1). Attendance at training sessions averaged 85 participants, with the vast majority from mental health or shelter sectors, with considerable experience (average almost 10 years) in serving homeless populations. The training was very well received, with participants giving high ratings to the comprehensiveness of information (average of 4.1 on a 5-point scale) and overall satisfaction (average of 4.0 on a 5-point scale). Common suggestions for the improvement of training were more use of examples/illustrations, more time for discussions, and involvement of more diverse stakeholders (i.e., people with lived experience). Areas for further training included strategies for local implementation and managing resources and resource limitations. Most participants had already heard of HF, and came to the workshops with a strong motivation to implement change, but had not yet taken steps to do so.

[1] Although initial training was provided in Halifax, no formal evaluation was conducted.

Table 1

Summary of Key Evaluation Ratings for MHCC/PHSI Initial Community Training Workshops

Sites	Attendance	Number of Evaluations Completed	Comprehensiveness	Overall Satisfaction
Fraser	50	43	4.0	4.2
Saskatoon	47	38	4.0	3.7
Winnipeg	110	82	4.1	4.1
Waterloo	155	112	3.9	3.8
York	62	27	4.3	4.2
Average / total / % of all participants who completed an evaluation	85 / 424	60 / 302 / 71%	4.1	4.0

Note: Ratings are on a 1-5 scale with 5 as the most positive rating.

While evaluations for initial workshops were generally positive, trainers encountered some resistance during the training sessions, particularly during the early days of the project shortly following the announcement of the HPS mandate shift, and the ensuing uncertainty within the homelessness prevention sector. In Winnipeg, for example, there was obvious friction during the stakeholder meeting, which was called very shortly after the HPS announcement and release of the Winnipeg report on ending homelessness – both of which raised the level of anxiety for some providers within the homelessness services sector. Resistance was also expressed by some participants in Halifax, who indicated they were angry with the presentation on HF, because it suggested that what these providers had done thus far was ineffective. As mentioned previously, another common sentiment expressed in many jurisdictions during training was the notion that providers were "doing HF already." Overall, the initial training workshops helped clarify the definition of the HF model and influence an increase in positive perceptions towards HF. The information provided through the workshop helped to counteract negative misperceptions of the approach and ease feelings of tension or resistance that emerged among some stakeholders in response to the HPS change that created fundamental changes in community process and program funding allocation.

Second training. All of the PHSI communities received follow-up training delivered by Pathways to Housing through the MHCC. In Winnipeg, Waterloo, and York, a single second training workshop was provided. In Fraser Valley and Saskatoon, two follow-up training workshops were delivered with the latter workshop conducted in conjunction with the fidelity assessment. In Halifax, one follow-up training workshop was provided and this workshop occurred in conjunction with the fidelity assessment. As with the initial training, most participants were affiliated with mental health organizations or shelters and housing agencies and held roles in direct service provision or leadership/administration. Second training workshops were tailored to each

community. In each community, a portion of workshop participants had not attended a previous HF training session. For this reason, second workshops often included an overview of HF followed by more specific information on HF related to local needs, such as HF fidelity, partnership-building, early implementation challenges, home visits, team approaches to HF, motivational interviewing, etc. Very similar to the first training, the second training was very well received, with participants giving high ratings to the comprehensiveness of information (average of 4.0 on a 5-point scale) and overall satisfaction (average of 4.0 on a 5-point scale) (see Table 2). Participants indicated that they particularly benefitted from opportunities to network and connect with other attendees and found it helpful to engage in presentations/discussions on specific topics related to HF and to participate in case discussions.

Table 2

Summary of Key Evaluation Ratings for MHCC/PHSI Second Training Workshops

Sites	Attendance	Number of Evaluations Completed	Comprehensiveness	Overall Satisfaction
Fraser Valley - Surrey	101	17	3.6	3.5
Fraser Valley – New West	35	18	-	3.7
Saskatoon	35	16	3.5	3.6
Saskatoon	30	11	4.2	4.2
Winnipeg	100	26	4.4	4.5
Waterloo	50	39	4.0	3.8
York	40	19	4.2	4.2
Halifax	10	8	-	4.0
Average / total / % of all participants who completed an evaluation	50 / 401	21 / 154 / 38%	4.0	4.0

Notes: Mean response rating not calculated due to an insufficient number of responses received for this item. Ratings are on a 1-5 scale with 5 as the most positive rating.

Fidelity assessment. Members of the TTA team participated in program fidelity assessments along with PHSI researchers. The in-depth nature of the fidelity assessment process provided members of the TTA team with more nuanced and detailed knowledge of the "day to day" activities of staff that served to expand their awareness of the local community context. TTA team members considered knowledge of the local context to be of high importance in their role

supporting communities on an ongoing basis over the course of the PHSI project. The fidelity assessments provided an opportunity to identify and begin to address "real world" issues experienced by staff. The assessment process also served as a means of identifying gaps in knowledge and skill that could be addressed through further TTA. Assessment reports provided to communities summarized scores on each domain of fidelity and included recommendations to guide HF teams in expanding or enhancing their local HF practices to better meet local needs (e.g., increased use of person-centered planning, increased capacity to support indigenous participants, using peers support workers more effectively, etc.). Participants responded positively to the HF fidelity assessments, as they appreciated the opportunity to focus on specific activities locally and engage in assessment debrief discussions with the TTA team and PHSI researchers. Many found the assessments to be informative and validating of their own values and practices.

PHSI phone calls and meetings. Over the course of the project, PHSI team members engaged in regular (usually bi-monthly) conference calls with project partners, during which updates were provided on HF planning and implementation. MHCC, PHSI, and Pathways staff participated in several of these calls for some sites, which effectively functioned as informal planning and implementation consultations. Halifax, for example, held several calls with MHCC/Pathways staff to assist in problem-solving related to pilot planning, partnership development, and strategic communication. These calls also enabled trainers to tailor subsequent TTA activities with projects sites' needs, and may have supported the capacity of conveners and champions to move implementation forward.

Members of the PHSI national steering team met as needed to provide updates on the progress being observed at each site and progress on project activities. Discussions also included updates influencing the national context including new national initiatives engaging PHSI sites (e.g., the 20,000 Homes campaign) and planning updates regarding the transition of the TTA provision role from MHCC to the Canadian Alliance to End Homelessness (CAEH) in 2016. An in-person meeting of the PHSI national steering team and community partners was held in Vancouver during the 2014 CAEH conference. This meeting provided a foundation for discussion to envision the development of regional networks.

Common themes related to the effectiveness and impact of training and technical assistance. There were several themes related to factors related to the effectiveness of the TTA in helping communities adopt, expand, or enhance the HF model. We elaborate on these themes below.

***Creating conditions for receptiveness*.** The PHSI project experienced varying degrees of receptiveness to its training across communities. The main challenge was in Montreal, where despite the need for training the MHCC/PHSI TTA initiative, because of its association with the At Home / Chez project that was perceived by key decision-makers as externally imposed. Also, two organizations who expressed initial interest in the training turned out subsequently not to be ready. In Toronto, training was perceived as less of a "value-add" given familiarity and local capacity with regard to HF implementation with both At Home / Chez Soi and the city-managed Streets to Homes having been implemented there. There was an organized association of supportive housing agencies who believed that they were already doing HF-type practice.

Both Montreal and Toronto also represented large, complicated metropolitan areas where, in contrast to the mostly smaller geographical areas in the other PHSI communities, it was difficult

to find a clear point of entry or single point of responsibility. For example, in Toronto, among other issues, the city served as the CE and received the federal HPS funding. It was not feasible for the city to identify which of their many homeless services were paid for by exclusively by the HPS funds. The MHCC/PHSI project dealt with this by shifting its operations to a specific area of Greater Toronto (York Region) where the community could more clearly identify sources of funding and programs and, more importantly, was at an exploratory stage of HF. In Montreal, training is still an unmet need at this point, though key informants indicate that one MHCC TTA trainer is still based in Montreal, and the community-based HF program that was part At Home / Chez Soi is still in operation and providing some training, though not through the MHCC. In contrast, in other communities, there was generally a clear point of entry through either non-profits or community groups through which TTA could be delivered. These were also communities that actively sought out participation in the project, saw a clear need, and welcomed the chance to participate.

Addressing concerns and misunderstanding. In the communities that embarked on the training, two common initial sources of concern were expressed, particularly by clinical service providers. The first was the notion that "we are already doing Housing First." For instance, supportive housing providers who used low-barrier approaches equated their approach with HF. The TTA team addressed this by clarifying that HF principles emphasize choice, as well the provision of intensive individualized support and that housing and services are managed as separate domains.

The second initial challenge was addressing doubt regarding whether the environment in the local community made high-fidelity implementation of HF feasible (e.g., low vacancy rates, clientele whose needs were particularly challenging or unique). An associated concern was that the HF model, particularly the use of scattered-site apartments, would not work for the typical homeless clientele in that community.

The TTA addresses these perceptions first by emphasizing that the substantial body of research that documented that in fact, it is not possible to predict who will or will not succeed in HF based on clinical or demographic features. The trainers also emphasized the adaptability of HF to specific populations (e.g., Aboriginal people, individuals with primarily addiction issues, etc.).

A final point of emphasis was the model's success in procuring apartments and facilitating housing choice even in communities with low vacancy rates and rural areas. There was a widely held perception that the low vacancy rate or the general unavailability of affordable housing would make implementation of a scattered-site, community-based apartment model impossible. It was useful to point out that in these discussions we are addressing two very different and seemingly contradictory aspects of the housing affordability problem. On the one hand, it is accurate that in the overall real estate market there is a shortage of affordable units. On the other hand, it is simultaneously accurate to observe that for the relatively small number of individuals in the community who qualify for HF programs a small number of apartments have been found in every city where the program has been implemented. The key to successfully securing units is to ensure that the HF program has access to rent supplements over and above the government shelter allowance. Rent supplements make the program a competitive bidder in a tight housing market.

Playing the convenor role: Consolidating local implementation capacity. In addition to its role in disseminating accurate information about the HF model and its implementation, anoth-

er perhaps inadvertent implementation role of the MHCC/PHSI project was its convenor role. As an outside entity, the MHCC/PHSI project, and the associated training, represented a neutral space for potential partners to gather, and engaged in dialogue aimed at forging a common vision. For instance, in Saskatoon, where the United Way had initially played a convenor role, the MHCC/PHSI project appeared to provide space where the United Way's P2EH could be aligned with the CAB's own HF Community Plan. In other communities, the project provided a venue for decision-makers from housing and mental health to partner. While these sectors are both instrumentally involved, it was not uncommon for decision-makers from these sectors to be unfamiliar with one another.

Providing information tailored to the local context. TTA activities were tailored to the local context of each community with the help of the local partners. Case discussions during workshops and fidelity visits provided an opportunity for targeted discussion between community stakeholders and the TTA team that focused on HF implementation issues experienced within each local community context.

Playing a connector role: Fostering opportunities for ongoing peer-learning. Over time, the TTA team gained increased knowledge of the context of each community and developed professional relationships with community leaders. This knowledge of the local context allowed the TTA team to begin connecting leaders in different communities who were experiencing similar challenges and/or navigating similar stages of implementation. These connections facilitated peer-learning and the sharing of resources. They also complemented existing local or regional peer-learning opportunities, as they sometimes connected communities located in different regions. Sustained challenges in TTA included meeting the need for ongoing training and technical assistance, navigating the diverse learning needs of community stakeholders, and balancing divergent approaches to TTA. These challenges provide insights into areas of development for HF TTA in the future.

Meeting the need for ongoing training and technical assistance. Time and resource limitations in the project limited the extent of TTA provided to each community. Despite the TTA content being tailored to each community, some communities indicated a need for training to be more closely linked to the local context. Furthermore, the continuous nature of the implementation process created a need for ongoing training. More frequent opportunities for community "check-ins" were a means of providing assistance in the change process inherent in HF implementation. The provision of ongoing training was necessary to negate the loss of skills and knowledge that occur as a result of turnover amongst staff and community leaders in the homelessness sector.

Navigating the diverse learning needs of community stakeholders. Participants in the TTA workshops, both initial and follow-up workshops, had different levels of skill, knowledge, and experience with HF. The content of the workshops had to include foundational information on HF as well as content on topic specific areas. There is a continued need for TTA and information resources to help communities at more advanced stages of implementation, particularly around adapting HF to local contexts (e.g., mid-sized cities) or for specific populations. The development of advisory groups for HF adaptation is a possible means of establishing guidelines for common forms of HF adaptation (e.g., HF for youth, HF for indigenous populations).

Balancing divergent approaches to training and technical assistance. A challenge faced by the PHSI project was that communities had hired other HF trainers whose advice and TTA were sometimes at odds with the Pathways HF model. Particular differences in emphasis lay in the approach to housing provision (addressed by the housing specialist in Pathways, versus a task of the clinical team), and with the approach to prioritization (emphasizing mental health, addiction and other clinical vulnerabilities in Pathways model versus the emphasis on medical vulnerabilities and frequency of services utilization emphasized by the VI-SPDAT).

Pathways training offered by the PHSI project also tended to be consumer-driven and program-based, rather than oriented towards helping communities develop a system of identification, prioritization and disposition designed and operated primarily by administrators or providers. There was confusion and, at times, tension between the values and practices of the Pathways HF TTA approach and the more systems-oriented, assessment-focused approach offered by others. The contrasting approaches to HF implementation were identified as a source of confusion and frustration for community stakeholders throughout the project. In the future, the challenge will be to find ways to integrates these two approaches. While these two approaches have been in tension, they may in fact represent complementary approaches, given that implementation of HF entails attention to both program and system-level issues as well increasingly diverse subgroups in the homeless population which require disparate sources of knowledge and expertise

Question 3 – What Are the Outcomes of Housing First Implementation?

Three main outcomes of knowledge transfer process in the six communities were examined: (a) the implementation of HF programs, (b) the fidelity of the new programs to the HF model, and (c) systems transformation.

Implementation of HF programs. In the six communities, 14 new HF programs were created and another nine programs were enhanced or sustained, for a total of 23 HF programs in the six communities (see Table 3). The majority of HF programs (19) are in the Fraser and Winnipeg communities, the largest urban areas. All the other communities have one or two HF programs. Also, both Fraser and Winnipeg have a prior history of HF programs through At Home / Chez Soi. Fraser's programs were influenced by a HF program in Victoria, BC, and the Vancouver At Home / Chez Soi HF programs. While the Fraser area encompasses many suburbs of Metropolitan Vancouver, the neighbouring City of Vancouver had three HF programs during the At Home / Chez Soi research demonstration project, one of which has continued. In Winnipeg, all three At Home / Chez Soi HF programs were sustained.

Fraser has a combination of ACT and ICM programs, while the predominant support model in the other five sites is ICM. While most of the new HF programs focus on people experiencing chronic homelessness and mental illness, the HF model was also adapted in programs to serve youth in general, LGBTQ youth, women, seniors, and Aboriginal people. During the course of the research, all of the new programs moved through the initial *exploration* and *installation* stages of implementation and are now in the stages of either *initial* or *full implementation*, as determined by the criteria for attaining each stage developed by Chamberlain et al. (2011).

Table 3

New, Enhanced, or Sustained Housing First Programs in the Six Communities and their Stages of Implementation

Communities	New HF Programs	Enhanced or Sustained HF Programs	Type of Support	Fidelity Assessment Completed	Stages of Implementation at Project's End
Fraser	Abbotsford / Mission Team		ACT	Yes	Initial implementation
	Surrey / Delta Team		ACT	Yes	Initial implementation
	Surrey Team operated by RainCity		ICM	No	Initial implementation
	Elizabeth Fry Multi-agency Team for women exiting the justice system		ICM	No	Initial implementation
	LGBTQ youth operated by RainCity		ICM	No	Initial implementation
	Aunt Leah's program for youth exiting foster care		ICM	No	Initial implementation
	BC Seniors' Services and Housing Information		ICM	No	Initial implementation
		Surrey Team	ACT	Yes	Full implementation
		New Westminster / Tri-Cities Team	ACT	Yes	Full implementation
Saskatoon	Journey Home		ICM	Yes	Full implementation
Winnipeg	West Central Women's Re-source Centre HF program		ICM	No	Initial implementation
	Eagle Urban Transition Centre Aboriginal HF program		ICM	No	Initial implementation
	RaY HF youth homelessness		ICM	No	Initial implementation

	program				
	Beaver Medicine Bundle (Ma Mawi Wi Che Itata Centre) youth HF program		ICM	No	Initial implementation
		Mount Carmel Clinic	ACT	Yes	Full implementation
		Wi Che Win HF team (Ma Mawi Wi Che Itata Centre)	ICM	Yes (self-assessment)	Full implementation
		NiApin HF team (Aboriginal Health and Wellness Centre)	ICM	Yes (self-assessment)	Full implementation
		HF CMHA	ICM	Yes	Full implementation
		HF Project Breakaway for chronically homeless	ICM	No	Full implementation
Waterloo		STEP Home	ICM	Yes	Full implementation
		Thresholds	ACT or ICM	No	Full implementation
York	Housing 2 Health		ICM	Yes	Initial implementation
Halifax	Mobile Outreach Street Health		ICM	Yes	Initial implementation

Fraser. Municipal impetus to address homelessness together with a provincial initiative to develop ACT teams in the mental health system in British Columbia enabled Fraser to link ACT with HF to focus on people with lived experience of mental illness and homelessness. All of the existing and new HF programs in Fraser have been created since 2012, so they all are of recent vintage. Fraser Health runs the five HF ACT teams. Two of the HF ICM programs are operated by RainCity, which continues to be the host organization for an ACT HF program in downtown Vancouver that was one of the At Home / Chez Soi project programs.

Saskatoon. Journey Home is a HF program that began in 2014 in Saskatoon. It is a program of the Saskatoon Crisis Intervention Service and is primarily funded by the United Way, with some funding provided through the Saskatoon Housing Initiatives Partnership (SHIP), which is the CE for Saskatoon. Originally, 22 people who had experienced chronic homelessness were targeted for this new program, but as of 2017, the number of program participants has

grown to approximately 50. SHIP also provides funding for Rapid Rehousing teams run on HF principles, as well as other emerging HF teams.

Winnipeg. In Winnipeg, the three At Home / Chez Soi programs have been sustained (McCullough & Zell, 2016). As well, the Community Housing with Supports program of the Canadian Mental Health Association (CMHA) and Project Breakaway of the Main Street Project have continued. Four new HF programs were created in 2015, one for women, one for youth, one for Aboriginal youth, and another one for Aboriginal people. Following the release of The Plan to End Homelessness in Winnipeg in 2014, a new body End Homelessness Winnipeg was created. End Homelessness Winnipeg, the City of Winnipeg (which is the CE/CAB), the Winnipeg Regional Health Authority (WRHA), and community agencies aligned to focus on enhancing and expanding HF in Winnipeg. In 2015, HPS funded a coordinated and centralized intake process to identify and house persons experiencing chronic homelessness. In 2016, the Health Outreach and Community Support (HOCS) team of WRHA was expanded to seven full-time staff positions to assist all of Winnipeg's HF programs with implementation and clinical case issues.

Waterloo. STEP Home is Waterloo Region's HF program. Operating since 2008, STEP Home consists of support workers from 12 interconnected agencies. In 2015, 40 housing allowances (rent subsidies) were provided for STEP Home clients, and as of 2017, 60 more have been allocated, bringing the total number of housing allowances available to clients to 100. As well, STEP Home is developing more of an ICM team model in one of the areas served. Finally, as part of the 20,000 Homes campaign, the Region of Waterloo has surveyed the region's homeless population and developed a list that prioritizes those experiencing persistent homeless for STEP Home services and the housing allowances. Although the Region of Waterloo is the CE/CAB for the region, the majority of funding for STEP Home comes from the regional government. Thresholds is a mental health housing agency that has both ACT and ICM teams for people experiencing mental illness. In 2015, Thresholds received and implemented eight new rent subsidies for people with lived experience of mental illness and homelessness.

York. Housing 2 Health (H2H) is the newest HF program in this research. The CE/CAB, that supports this program, transitioned from the United Way York Region to the United Way Toronto and York Region (UWTYR). UWTYR has taken a convener role in the planning of HF in York Region. H2H is a partnership between Blue Door Shelters, the Krasman Centre, Loft Community services, and CMHA-YR. The ICM team currently has a team lead and two Peer Support Workers. Rent subsidies for clients have yet to be obtained in H2H.

Halifax. HF planning in Halifax has been driven by two semi-independent processes led by the AHANS and the United Way Halifax (UWH). AHANS has been the CE/CAB for Halifax since 2012. Mobile Outreach Street Health (MOSH) of the North End Community Health Centre (NECHC) was selected as the program to provide HF ICM services to people experiencing chronic homelessness. Currently, 57 participants are served by this program. Funding for the program is provided by Housing Nova Scotia, the Nova Scotia Health Authority (for seconded staff from NECHC), and HPS.

Program fidelity. External fidelity assessments by a Quality Assurance Team were conducted for 10 of the 24 programs (see Table 3). The project and the Quality Assurance Team did not have the capacity to conduct fidelity assessments for all of the 19 programs in Fraser and

Winnipeg, some of which came in too late in the PHSI project to undertake a fidelity assessment. In Table 4, the scores for each program on each of the five fidelity domains are reported, as well as the total average score.

For comparison purposes, the average scores for 10 At Home / Chez Soi HF research demonstration projects conducted early and later in implementation are included (Macnaughton et al., 2015). It is important to note that the fidelity levels achieved by the At Home / Chez Soi programs represent the "gold standard" for HF programs. At Home / Chez Soi programs were very well funded and resourced. Program budgets for staffing, the provision of rent subsidies, ongoing training in the HF model by experienced Pathways staff, community of practices for program staff, and two external fidelity assessment provide ideal conditions for the incubation of HF programs. In contrast, the new HF programs created in the six communities represent more "real world" conditions, in which budgets are constrained; rent subsidies are challenging to access; training is more limited; implementation barriers are numerous; and local champions must scramble to put a HF program together with multiple partners and funding sources.

The total average scores for the 10 new, enhanced, or sustained programs is 3.3/4, which is just slightly lower than total average score of 10 At Home / Chez Soi programs, which was 3.5 at early implementation. All programs had a total average score of greater than 3.0/4, indicating a relatively high level of fidelity to the HF model. The highest average score for the programs was 3.8/4 for the Separation of Housing and Services, which is comparable to that obtained for the At Home / Chez Soi programs. The lowest total average score for the programs was 2.8/4 for the Service Array domain, which again is quite similar to that obtained during the early implementation of the At Home / Chez Soi programs, which was 2.9/4. Service Array is particularly challenging for ICM programs during early implementation because the program staff must create many different partnerships with other agencies to broker services for clients. Note that in At Home / Chez Soi, the total average score for the Service Array domain improved to 3.4/4 by later implementation, one year after the early implementation fidelity assessment. Over time, similar improvement in the Service Array domain may occur with the new, enhanced, or sustained programs. Improvement in other domains for some programs is likely to occur because of specific steps that have been taken to enhance the programs. For example, in Waterloo, the number of rent subsidies available at the time of the fidelity assessment was 40, which hampered its score on Housing Process and Structure. With the addition of 60 more rent subsidies, the score on this domain would likely increase.

Table 4

Scores of Housing First Programs on External Fidelity Assessment in the Six Communities[a]

Community	Program	Fidelity Domains					
		Housing Process and Structure	Separation of Housing and Services	Service Philosophy	Service Array	Team Structure / Human Resources	Average
Fraser	Surrey (ACT)	3.6	3.9	3.2	3.5	3.3	3.5
	New Westminster / Tri-cities (ACT)	3.7	3.6	3.2	3.3	3.7	3.5
	Abbotsford / Mission (ACT)	3.2	3.8	3.3	3.6	3.6	3.5
	Surrey / Delta (ACT)	3.2	3.9	3.3	3.7	3.6	3.5
Saskatoon	Journey Home (ICM)	3.9	3.7	3.3	3.6	3.7	3.6
Winnipeg	Mount Carmel Clinic (ACT)	3.7	4.0	3.3	3.1	3.8	3.6
	CMHA Community Housing with Supports (ICM)	3.5	4.0	3.5	1.8	2.9	3.1
Waterloo	STEP Home	2.9	3.6	3.0	2.8	3.0	3.1
York	Housing 2 Health	2.4	3.8	3.6	2.4	3.4	3.1
Halifax	Mobile Outreach Street Health	4.0	3.9	2.9	3.3	3.3	3.5
Average score		3.4	3.8	3.3	2.8	3.4	3.3
Average score for 10 At Home / Chez Soi Programs	Early (9-13 months)	3.6	3.9	3.6	2.9	3.5	3.5
	Late (24-29 months)	3.6	3.9	3.6	3.4	3.5	3.6

[a]Note that all scores are on a 1-4 scale, with high scores indicating a higher degree of fidelity.

In Winnipeg, fidelity self-assessment data were gathered for the three At Home / Chez Soi programs for another study (McCullough & Zell, 2016). These findings are reported in Table 5. The same fidelity domains are examined with the self-assessment measure. While the external fidelity assessment and the fidelity self-assessment use different methods, for the Mt. Carmel ACT program, we have both external and self-assessment data that yield very similar findings. The total average score for the external assessment was 3.6/4, while the total average score for the self-assessment was 3.7/4. The three sustained Winnipeg At Home / Chez Soi HF programs

had total average scores ranging 3.3/4 to 3.7/4, indicating that all three demonstrated relatively high fidelity.

An important limitation of this research is that none of the new HF programs in Fraser and Winnipeg that were adapted for populations other than those with mental illness (i.e., youth, LGBTQ, seniors, Aboriginal people) were tested for fidelity. Thus, the fidelity of these HF programs, which includes all of the new HF programs in Winnipeg, is unknown.

Table 5

Self-assessment Fidelity Scores by Domain for the Three Winnipeg At Home / Chez Soi HF Programs After the Demonstration Phase

Program	Fidelity Domains					
	Housing Process and Structure	Separation of Housing and Services	Service Philosophy	Service Array	Team Structure / Human Resources	Average Score
Wi Che Win (ICM)	2.9	3.7	3.8	2.7	3.4	3.3
NiApin (ICM)	3.3	4.0	3.8	3.3	3.5	3.6
Mount Carmel Clinic (ACT)	3.0	4.0	4.0	3.6	3.6	3.7
Average Score	3.1	3.9	3.9	3.2	3.5	3.5

[a]Note that all scores are on a 1-4 scale, with high scores indicating a higher degree of fidelity.

Systems transformation. Systems transformation was viewed by participants as existing at several different levels of analysis: (a) changes in the mindset of systems' stakeholders, (b) coordination, collaboration, and capacity-building among local systems' stakeholders, and (c) policy changes.

Changes in the mindset of systems' stakeholders. First, participants noted that the shift to a HF approach requires a change in the mindset of systems' stakeholders (i.e., practitioners, planners, funders, policy-makers). This mindset includes a fundamental belief in consumer choice, community integration, and recovery. In Saskatoon, for example, the early success of the Journey Home HF program was believed to contribute to a change in mindset.

> "[The Journey Home] has really transformed how people are approaching things in the community and [we're] getting some [new players] to come forward and say, 'Okay, we think we can do this.' For instance, the Indian Metis Friendship Center [is] providing case management now. You know, five years ago I don't think that would have been even within the realm of their thoughts. … It's really this, this pioneering movement and [the Journey Home], has [been on] the front end doing all this work. It's really made it, I'd

> say more acceptable of a practice to provide Housing First." (Saskatoon focus group participant)

However, stakeholders at other sites noted that the HF mindset is often not shared outside of HF program staff and supporters. Even in places where HF is expanding, like Winnipeg, participants noted that some stakeholders in the homelessness system still do not fully grasp the core principles of HF.

> "We're still kind of at the ground stage of developing that real understanding of what is Housing First. There are lots of comments and we go, 'That's not Housing First!' But I can't be really controversial about it, because it's still in the partnership development stage, and it's baby steps and learning as you go. We've got a long ways to go in terms of [the whole system] developing knowledge and skillsets around Housing First with the whole system." (Winnipeg focus group participant)

Coordination, collaboration, and capacity among local systems' stakeholders. A second level of systems change involves the coordination, collaboration, and capacity among local systems' stakeholders.

Coordination. There are two clear indications of increased coordination and interconnections among Winnipeg stakeholders. First, while there was initially a lack of alignment between the City of Winnipeg's plan for homelessness programs under the new HPS mandate of HF and the United Way-led Poverty Reduction Council's 10-year plan to end homelessness, these two planning processes became inter-connected over time. Second, the City of Winnipeg funded the development of a coordinated intake system that involves seven HF programs assessing, prioritizing, and assigning people experience homelessness to HF programs.

Saskatoon's two parallel but disconnected plans to address homelessness, one by a community-led group, the United Way's Plan to End Homelessness (P2EH), and the CE's five-year community plan also became more aligned over time, and its HF program Journey Home, though housed by Crisis Services, involves collaboration between multiple agencies. Another key systems change initiative in the Region of Waterloo has been an assessment of the homeless population as part of the 20,000 Homes campaign, and the development and implementation of a priority list process. Similar steps have been taken in York Region. York's HF program, H2H, is also a multi-agency endeavor, and York Region has conducted a point-in-time count and begun to use the VI-SPDAT (Vulnerability Index – Service Prioritization Decision Assessment Tool).

In Fraser, participants noted agency change but pointed out the need for better systems coordination, including between the more established HF ACT teams and the newer ICM teams.

> "I think the homeless serving system somehow needs to collectively have dialogue around, the transformation itself, whatever that might look like, whether, you know, so there's coordination around Housing First in that system." (Fraser focus group participant)

Collaboration. To effectively coordinate various system components and players, collaborative processes are required. In Winnipeg, participants perceived that there had been a "radical transformation in collaboration among agencies." While there was much anxiety during the tran-

sition from the At Home / Chez Soi research demonstration project to provincial funding, that uncertainty has dissipated over time with funding from the province and HPS. Whereas at the beginning there was an unhealthy "divide and conquer" mentality, participants believed that agencies had "moved toward one another." Stakeholders who were previously disconnected slowly realized the need to cooperate rather than compete with one another because of their shared interests and local, provincial, and policy directions regarding the HF approach to homelessness.

Collaboration regarding homelessness planning and HF program implementation was also noted by in York Region. According to one York participant:

> "So, we make sure at that CAB we [have] the systems people there. We have the region. We have the police. We have community members. We've got business. We've got landlord associations sitting there. And, so that is that voice and looking at a systems level. And, so and it's new as well." (York focus group participant)

In Halifax, the HF initiative catalyzed joint planning and information sharing across service providing agencies through the CAB.

> "I think that the change in the HPS program…made people come to the table. So that one program change brought community to the table in a way that they didn't have to come to the table before. So…that period was a period of constant conversation, both one on one and through the CAB and through community meetings with an HPS bias mind you, around Housing First, and…the building of our own set of Housing First principles that would be applying to our initiative. So…I think HPS was the catalyst that brought them together, and the rest unfolded from there." (Halifax focus group participant)

Capacity. Systems capacity to serve people experiencing homelessness through the development of new, high fidelity HF programs, noted earlier. The Region of Waterloo has completed a systems re-design process for supportive housing and the emergency shelter system to enhance the capacity of the local housing and homelessness system. New systems for identifying and prioritizing people experiencing homelessness for services in most of the communities also increased community capacity.

Earlier we underscored the importance of TTA for HF capacity-building for the 6 communities participating in this research. Moreover, participants argued that there is a need for ongoing TTA to sustain and enhance the HF approach. To this end, TTA support transitioned from MHCC to the CAEH in 2016. Funded by HPS, this TTA will continue through 2019.

Another model for TTA is the HOCS team developed in Winnipeg through the WRHA. In early 2016, Manitoba Health supported an increase to expand the HOCS team from 1.5 clinical positions to 7 individuals to provide clinical capacity to support the shelters and HF teams. The HOCS team consists of a Clinical Coordinator (a full-time Social Worker), a Clinical Facilitator (a full-time Nurse), an Occupational Therapist (full-time), a Trauma Worker (a full-time Social Worker), a Community Services Coordinator (full-time Outreach Worker), a Psychiatrist (half-time), and a Ph.D. Clinical Psychologist (.4). HOCS is coordinated by an Initiative Leader (a full-time M.A. Community Psychologist). These staff members work across the programs as a collaborative team and provide some direct clinical services and some consultation and support

for staff in the clinical issues. HOCS can leverage needed services that would be difficult for external agencies to access. Two of the HOCS positions (Trauma Worker and Clinical-Community Psychologist) are located within two HF agency locations to be integrated and accessible. The agencies have embraced this model and, according to one Winnipeg focus group participant, no one has said "why didn't we get a worker housed in our agency?" The development of this team came with the addition of some key experienced staff that moved from direct service management roles to HOCS. Moreover, as four of these HF programs are also funded by WRHA in the same division as HOCS, the programs work collaboratively to operationalize the fidelity of HF and have a strong base of implementation support.

Another important aspect of capacity is organizational and community leadership. This could involve the leadership provided by one organization, such as the Region of Waterloo Housing Services in Waterloo Region. In Winnipeg, one participant noted the importance of the leadership provided by WRHA.

> "There have been a lot of partnerships starting to be developed and continuing to be developed, you know. I look across the table at WRHA. I think that was a real key piece in regards to discussing and figuring out things as we kind of move forward. They've taken over the AHCS groups and organizations. So, I definitely say that WRHA, as one provincial body, has been a key stakeholder." (Winnipeg focus group participant)

More often than not, however, there was shared leadership among two or more stakeholder organizations in the communities. The local CE/CABs, United Ways, health authorities, and Aboriginal organizations were the typical lead organizations with HF champions. These organizations convened other organizations for systems planning, capacity-building, and HF implementation.

Policy changes. Policy changes can occur at several levels: (a) local, (b) provincial, and (c) federal. Policy change is very fluid and it is difficult to distinguish how policy aids in the development of HF programs or whether it occurs as a result of HF research evidence and TTA in HF.

Local. Local policy change was quite variable across the sites. A clear change in local policy is evident in Waterloo Region. Following an evaluation study that demonstrated the positive impacts of rent assistance that was piloted in the STEP Home program (Pankratz & Nelson, 2017), the Region of Waterloo increased the number of housing allowances from 40 to 100. Winnipeg is another example of where the City of Winnipeg, WRHA, End Homelessness Winnipeg, and Aboriginal organizations came together to sustain and enhance existing HF programs, as well as creating new HF programs. York Region also aligned local stakeholders to create its first HF program, but it is struggling in its initial implementation to obtain rent assistance for its clients. Participants in Fraser, BC, also noted that HF, including rent supplements, had become a key component of the strategic plans in the Fraser Health Authority.

Provincial. Provincial policy change has been more limited. One case in which provincial policy change assisted the development of HF programs is BC. The emphasis of ACT in BC's mental health plans facilitated the development of new HF programs for high needs clients served by ACT. At the same time, both the Ministry of Health, through its Semi-Independent Living (SIL) program and BC Housing had some history with the provision of rent assistance.

Both of these provincial policy precedents contributed to the regional health authority's decision to fund the rent supplements that could be linked with ACT services to create new HF programs. Subsequently, a more recent shift in BC Housing policy opened up some further rent supplements that the ACT team has drawn upon to expand its pool of rent supplements.

Provincial funding for rent assistance was obtained in several of the sites, but most provincial governments lack a clear and consistent policy across ministries for the provision of rent assistance. For example, in the recent Ontario Supportive Housing Policy Framework (Government of Ontario, 2017), there is only passing mention of rent supplements or rent assistance.

Two participants noted the importance of provincial policies for rent supplements.

> "I guess that the hope for systems transformation, would be that in terms of the investment in homeless services that there would be a greater investment in these portable rent supplements." (TTA key informant interview)

> "Most provinces don't have a rent supplement system in place so they're working kind of within this long application process where it's one off per person… So, they seem to be working within the limitations of the current systems, the current policies to make it work… But I think the provinces need to do the same [as HPS has done at the federal level]. Like, I'd like to see the provinces mandating a portion of funding to Housing First… So, with Health as mandating… [and] providing rent sups, then get some real money behind it to create big enough programs where then you'll see those systems changes." (TTA key informant interview)

Another issue with regard to policy impacting HF implementation involves the linkages with mental health services. With the exceptions of Fraser and Winnipeg, mental health services, particularly in the form of ACT for high needs clients, was not available to HF teams. Rather, HF teams in other provinces had to employ an ICM model and broker mental health services. One participant noted the importance of having health providers on HF teams.

> "I think funding for every team to have mental health and health practitioners on the teams is really quite critical." (TTA key informant interview)

Federal. The shift in federal HPS policy to HF was perceived as contributing to the implementation of HF programs across Canada. One participant made the following comment in this regard.

> "I think that probably the most hopeful thing that HPS did was make a mandate that targets chronic homelessness and require communities to shift resources on a flat budget. If they really want to take it to scale quickly, I think that they would have to invest, enough money with the mandate so, it's like, you have to end chronic homelessness that's the target population, and here's the money for rent supplements and services to do it." (TTA key informant interview)

While helpful, participants noted that constraints on the length of time that rent supplements could be used under HPS guidelines and the amount of funding available from HPS limited the

scale of HF and the potential transformational impacts of HF if it were implemented on a larger scale. Two participants noted that the scale of HF implementation is not sufficiently large enough to create transformative change.

> "So, even though with the small sub-category [of chronically homeless people with mental illness], you have the potential of transforming the mental health system to make it recovery focused, it's not large enough. It's not represented … strongly enough… I think that, to some extent, I would say that to change systems, we're really too small a scale… We haven't achieved the scale… With the mandate, and the money, I think would be just further along." (TTA key informant interview)

> "I just don't know that Housing First is big enough in communities yet to really affect that really high level change. (TTA key informant interview)

One participant noted that homelessness occurs because of larger structural inequalities in income, and that more fundamental changes in federal policy are needed to reduce economic inequalities to eliminate homelessness.

> "I think I've become painfully aware … is the fact that all of this conversation about homelessness is we're still talking about symptom reduction, which [stems from] income disparity, rents that are beyond poor peoples' reach, the structural economic factors that continue to contribute to homelessness. So that, we can do all this, and like solve homelessness for the mentally ill, which is just a small subset of the homeless. It's small and it's also not even beginning to address the structural factors that continue to contribute to homelessness, so it's like, okay, we might get at this, but that would just mean we're becoming more efficient at managing the fallout of the structural problems." (TTA key informant interview)

Question 4 – What Factors Impeded or Facilitated Housing First Implementation?

This section describes some of the key activities that have occurred during the *exploration*, *installation* and active *implementation* stages within the PHSI communities. Although each community differed in its stage of implementation at the start of the project, its sequence of activities, and the local context, there have been some notable commonalities between sites. After briefly describing the main activities involved in each stage, we also describe the challenges and facilitators associated with moving implementation forward (see Table 6 for an overview of the barriers and facilitators at each stage of implementation.)

Table 6

Barriers and Facilitators during Stages of Implementation

Stages of Implementation	Barriers	Facilitators
Exploration	• Framing the problem and the solution • Community concerns • Lack of alignment • Lack of working relationships	• Readiness • Policy context • Champions/convenors • Time/timing
Installation	• Accessing resources • Service delivery context (remodelling vs. starting from scratch) • Moving beyond program-based allocation	• Congruent provincial/local policy context • Local champions/boundary spanners • Selecting compatible host agencies
Initial and Full Implementation	• Limits to housing choice • Rehousing • Service philosophy • Service array • Systemic barriers	• Optimizing housing procurement • Preventing housing loss • Intentionality regarding engagement and recovery • Reflective practice

Exploration. In the *exploration* stage, communities became motivated to address homelessness, brought various partners together to establish a common vision, and developed concrete plans for implementing HF. In three communities (Fraser, Saskatoon, and Waterloo), the exploration process was initiated in bottom-up fashion, in response to locally identified needs. Accordingly, in each of these places, the community had engaged in a planning process that preceded the PHSI project and the HPS policy shift. In Fraser, the city of Surrey had convened a Task Force that brought together key stakeholders to produce a plan. In Saskatoon, the United Way convened a P2EH, and in Waterloo, the regional government initiated a process to reorganize its housing and homelessness services. In two other communities (Halifax and York Region), the exploration process was driven more directly by the HPS policy shift, in the context of the five-year plans that local CABS were mandated to develop. Finally, in Winnipeg, HF adoption was initially driven by the At Home / Chez Soi project that preceded the PHSI initiative. Subsequent to At Home / Chez Soi, the United Way and an associated agency produced a Plan to End Homelessness that explored how to continue building HF capacity. In the context of this plan, and the HPS policy shift, the deliberations occurring during the PHSI project itself focused on efforts to sustain At Home / Chez Soi services, and on how the new HPS funding would be allocated.

Challenges impeding exploration. Challenges that required addressing at this stage included framing the problem, addressing resistance to HF, aligning different planning processes, and a lack of previous working relationships between key sectors.

Framing the problem. In some sites (Saskatoon, Fraser and, to a lesser extent, Waterloo), the exploration process was initiated by the emergence of a public issue that stimulated a process of problem framing, consensus-building, and problem-solving within the community. Prior to the HPS policy shift, however, it could take a while before the community came to define the problem in terms of homelessness, and before they landed on HF as a potential solution. In Saskatoon, for example, dialogue was initiated because of a concern by business owners with the activities of a group of street-entrenched individuals who frequented the downtown core. After setting up a task force related to street crime, community leaders eventually decided to look at the "root causes" of the problem, and conceptualized the problem as essentially about housing, rather than about community safety. Similarly, framing the solution as HF could also take time, as in the absence of a clear policy mandate, these communities needed to undergo an often lengthy exploration process before landing on HF as a viable solution. In the Fraser Valley community of Abbotsford, for instance, the initial plans focused on developing a resource hub for homeless people through which they could be eventually connected to available services. Later on, through its involvement in the Fraser site of the PHSI project, Abbotsford developed a HF ACT team.

Community concerns. Community concerns were a barrier to the early stages of HF implementation in some communities, particularly when HPS policy mandate came into play, and HF was perceived as being imposed in a "top down" fashion, rather than considered through an organic exploration process. One concern included agency perceptions that "we're already doing this," which may have been based on mistaken notions of what evidence-based HF comprises, as well as concerns about jeopardizing existing services. Said one TTA key informant:

> "In the way of barriers, what I remember vividly, Winnipeg, and not exclusive to Winnipeg, other communities as well complained about the shift in HPS mandate from all homeless people to just the chronic. And there was a lot of concern that families were left out, that youth was left out, legitimate concerns and that what's gonna happen to my domestic violence shelter. Those were some of the early resistances, particularly [from] shelters." (TTA key informant interview)

Lack of alignment of planning processes. When the HPS mandate came into effect, local CABs and CEs assumed a lead role in local HF planning. An initial challenge, however, was that the efforts of CABs/CEs were not always well aligned with those of others who had previously assumed a role in HF planning. As a result, previous planning leaders may have not been well apprised of the activities of the CAB/CE-led community planning process. For example, in Saskatoon, the CAB plan did not initially have close links with the previously existing P2EH. Through the PHSI project, and the efforts of both the CE and the United Way (host of the P2EH), the processes eventually became better aligned, so that CAB resource allocation decisions could complement those of the United Way.

Lack of working relationships. A closely connected challenge was the lack of existing working relationships among the individuals involved in the various planning entities, and among the various agencies that would eventually be involved in delivering the model, such as

between the homelessness and mental health sectors. At the outset of the implementation process, this could cause a seemingly formidable obstacle that could require a great deal of leadership to overcome. Said one key informant:

> "Leadership at the local level is very important to bring those partnerships together and make that [happen]. And, a lot of it depends on those local-level personalities. I mean, Halifax is one example. If you go back a couple of years, it was like, they didn't think they could do it." (federal government focus group key informant)

Despite the involvement of the mental health sector in some communities, developing relationships that brought mental health services to the table could be limited by perceptions that HF participants did not fit traditional service mandate criteria, and concerns about waiting lists and full caseloads. As one participant explained it:

> **"**Because, uh, cause homelessness is a, is a outlier, you know, like most people with mental illness are not homeless…And if your business is treating the mentally ill, homeless is a small sub-category." (TTA key informant interview)

Facilitators of exploration. Facilitators included previous experience with HF, the federal policy context, and local champions who could convene the various partners and help forge consensus about HF as a solution.

Readiness. Implementation progress to some extent depended on whether communities had engaged in previous HF planning work. Prior to embarking on the PHSI project, some communities (e.g., Saskatoon, Winnipeg) had embarked on a P2EH that included a HF component. Based on their plan, Saskatoon was in the process of moving forward on recommendations to implement a HF team. Similarly, previous experience with HF implementation through the At Home / Chez Soi project in Winnipeg increased community readiness to plan further HF programs when the HPS policy mandate shifted. These communities may have been further along in terms of embracing values associated with HF that otherwise may have been controversial (e.g., harm reduction). For example, Winnipeg's efforts during the PHSI project were grounded in their experience with At Home / Chez Soi and the commitment to HF and its principles expressed in their Plan to End Homelessness.

Prior to the HPS policy shift, motivated communities that lacked previous planning or implementation experience built readiness by consulting with leaders and by networking within the growing national and international HF movement. Fraser Health, for example, consulted with At Home / Chez Soi leaders, and with leaders from a HF program in Victoria. Saskatoon brought in experts from At Home / Chez Soi, the province of Alberta, and the city of Portland, Oregon.

Policy climate. Clearly, the shift in HPS policy mandate was a significant impetus to HF planning in all communities. By establishing a process for developing a Community Plan, designating a specific administrative entity (the CE), and mandating resource reallocation towards HF, the policy strategy enabled proponents of the HF approach to move forward with planning and active implementation. One key informant, while discussing the importance of the policy, said:

> "I don't think (implementation) would have gotten anywhere unless they had the HPS mandate…It's like, you know, if they were just trying to persuade people, I don't know if this would have gone where it went at all … I mean, it wouldn't have died, but it would have been like a few small projects." (TTA key informant interview)

While the policy elicited some resistance, key informants suggested the way it was implemented helped overcome that resistance. The policy shift was done in a collaborative fashion that built on previous Canadian experience with HF, both through At Home / Chez Soi and elsewhere, so that there was a considerable degree of "buy-in" about the model and the strong evidence in support of its positive impact. They also acknowledged that the importance of the training resources that came along with the shift, both by design and through the commitment of MHCC to fund its TTA initiative. As a government decision-maker commented:

> "For most communities, it's a huge shift and by being able to support six communities through the PHSI and then the Mental Health Commission's training and technical assistance, supporting others, [with] the HPS policy shift sort of demanding that communities move in this direction. Things were just really well aligned." (federal government focus group participant)

Champions/convenors. Another facilitator of exploration was having leadership within a given community for championing HF, and moving forward towards a collective vision. In the event of a community having more than one planning process, having this type of leadership facilitated alignment of the plans.

> "(M)ost of these communities [were] led by a local champion, either individual or agency.… like they led it and then they got everybody at the table who needed to make it happen… [For example,} the United Way in Saskatoon [persuaded] the community entity to kind of come along because they were putting up money and making movement [and] they were very influential community leaders." (TTA key informant interview)

As the quotation suggests, leadership could come from an individual, or collectively, from an organization that understood HF and could convene the community's stakeholders, bringing them together to move towards that vision. Effective convening organizations possessed credibility and some degree of neutrality so they were respected by all relevant players. As the Saskatoon example suggests, they also generally brought resources to the table, most often in support of the convening and planning process, but sometimes were able to direct resources directly to HF services. Another example was in Winnipeg, where the WRHA (the health authority) and the province were able to bring the various players, including the CE together and move forward on a plan to sustain the At Home / Chez Soi teams and support the creation of new teams.

Time/timing. A final factor influencing exploration was time or timing. In some communities (e.g., Winnipeg and Halifax) little apparent progress was made during the initial months of the PHSI project. When it happened, change accelerated quickly, seemingly out of nowhere. In both of these cases, it took time for different partners to become aligned, and for leadership to emerge. In Halifax, for instance, the eventual lead agency, MOSH, and another key partner, the Regional Health authority, had been preoccupied with organizational change issues.

When these were resolved and they were able to devote their attention to HF planning, the community began to move beyond the exploration phase into installation.

Installation. HF installation entails resource acquisition, both housing and supports, agency/staff selection, client prioritization, and, in some communities, the development of systems for coordinated intake.

Challenges impeding installation. Challenges that communities faced included accessing resources, particularly around housing subsidies, navigating a complicated service delivery context, and system-based (vs. program-based) resource allocation.

Accessing resources. While HPS policy provided support-related funding, a significant challenge for communities was in accessing resources for housing subsidies and for certain clinical supports. As one participant stated:

> "What was really, really hard was getting new resources into place so that we could implement the programs. That was the hardest part, by far the hardest – housing. How are we gonna' pay for housing? How are we gonna' pay for services?" (TTA key informant interview)

Particularly at the outset of the policy shift, federal policy restricted the use of HPS funds for housing subsidies to a short transitional period only. The intent behind the restriction was that communities would be able to access subsidies from provincial resources, but such funding arrangements were not in place at the beginning of implementation. This meant communities needed to secure housing subsidies from other sources (e.g., United Way, health authorities, private funding), which could also be a challenge. If provincial subsidies did become available for HF programs, they may have had restrictions in terms of their portability and duration.

The other resource challenge was around securing supports, particularly around more specialized clinical supports related to mental health and addictions. To access resources, these communities needed to develop partnerships with the mental health system. However, as mentioned, the homelessness sector did not always have strong previous working relationships with these other sectors, so accessing these resources could also be a challenge.

Service delivery context. Key informants noted that there was a challenge implementing HF in complicated service delivery contexts where there are multiple agencies and sectors. In such landscapes, where each of the agencies may have provided one aspect of the needed support, the various stakeholders tended to maintain a sense of ownership over "their clients." As a result, in some communities (e.g., York, Waterloo), the result was a multi-agency HF model. This could provide a challenge with respect to developing a clear system of accountability, and an effective, cohesive team approach to providing housing and support. At the same time, the multi-agency HF team would need to adapt itself to the existing structures and routines of the various agencies. While such challenges were not insurmountable, key informants suggested it could be easier to install an altogether new HF program, since there was no "remodeling" needed. Said one TTA key informant, "It's like remodeling of what was in place to put in the new thing. It was much more difficult and some of the remodeling had to do with existing practices and then shifting that." As another put it: "I think communities that have started the team from scratch have had an easier go of it, like Saskatoon" (TTA key informant interview)

Moving beyond program-based resource allocation. Implementing HF entails funding agencies, and also requires that resource allocation decisions are made with a view to establishing a coordinated system of care. This necessitates establishing a common (or coordinated) entry point using a common assessment tool for making decisions about the eligibility of clients and appropriateness of referrals. One challenge was that communities lacked the expertise for choosing appropriate tools necessary for defining the target population and then setting up a coordinated system of care. Said one participant:

> "This idea of coordination, this idea to what can [a given agency] do that fits into this piece that benefits all of us, you know. So, it's finding that way to move to the sort of systems thinking and that's not easy." (federal government focus group participant)

A related challenge was that CEs may have been uncomfortable making resource decisions based on a consideration of an agencies' potential role within an HF system of care, rather than on the historical funding patterns of specific agencies. A government funder acknowledged how:

> **"**very difficult on the community level [in a situation where we were] putting our CABs and CEs in a position where they really had to shake things up. So, people who had been traditionally funded for many years, were not going to be." (federal government focus group participant)

Facilitators of installation. Key facilitators included having a congruent provincial or regional policy climate and having convening organizations that enabled communities to pull together the necessary housing and support resources necessary for establishing a HF team. Another key facilitator was choosing a host agency with appropriate capacity and a supportive culture for HF implementation.

Congruent provincial/local policy climate. As mentioned, HPS federal policy facilitated HF planning and exploration. Congruent provincial and regional/municipal policy was significant for moving beyond planning to installation of HF, given that facilitative provincial and regional/municipal HF policy enabled communities to access resources for housing subsidies. For instance, the Fraser Health Authority, together with BC Housing, had a history of providing rent supplements to some of its other supportive housing programs. This provided a policy precedent that enabled the Health Authority to provide housing subsidies to a number of people on their ACT teams. Fraser Health subsequently expanded the number of housing subsidies by drawing on supplements that became available through BC Housing, under its new housing policy. In Fraser, a conducive provincial climate was also important on the support side, given that a provincial policy initiative to establish ACT teams led to the formation of the ACT teams that Fraser Health, by adding housing subsidies and targeting people experiencing homelessness, turned into its HF ACT teams.

Local champions/convenors/boundary spanners. In the exploration stage, it was important to have convening organizations to bring the relevant players together, and align previously disparate planning processes. The convening function was similarly helpful during the installation phase, as it allowed the community to bring together the different resources necessary for putting together a HF team. As one participant stated, "so what facilitated the implementation was, somebody at the local level figuring out how to get the money in place to pay for the ser-

vices and to pay for the housing" (federal focus group participant). This took a different sort of leadership than was necessary in the exploration phase. Said one TTA key informant:

> "When I was talking about leadership initially, I meant the power leadership, to convene a meeting and people show up. Right, and that's a different leadership than the content leadership, and they're not always inhabited by the same agency." (TTA key informant interview)

This "on the ground" or "content" sort of leadership was particularly important for ICM teams that needed to forge partnerships between their team and the formal mental health system. Developing these ground level partnerships was facilitated by having relevant partners (e.g., from both housing and mental health) at the planning table, which, through its "power leadership," the convening organization was often able to set up. For instance in Halifax, the leader of the CE was able to develop a strategic relationship with MOSH, the eventual lead agency, and with the Regional Health Authority through which the new HF team gained key staff members.

Selecting capable and compatible host agencies. Selecting lead organizations with appropriate capacity and compatibility with the HF model is a significant facilitator. Important selection criteria include familiarity with the clientele, practice expertise, and a conducive agency culture and values. As a key informant said about MOSH, the Halifax lead agency:

> "MOSH actually knows the people completely from the street, years of street outreach and now they have a Housing First team that they can refer people to so it's like the values, and practices and [the leadership]." (TTA key informant interview)

In some communities (e.g., Fraser), the formal mental health system, through its ACT team, plays a prominent role, providing services directly and playing the lead agency role. The advantage of this model is that it can provide strong clinical support on the mental health and addictions sides. In other communities (e.g., Saskatoon), the lead agency is housed in the community-based (or NGO) sector, through its ICM team. Teams based in this setting appear more familiar with the typical clientele, who often fall outside the mandate of the formal mental health system because of their more complex profile. They also tend to have an appropriately flexible style of practice that is recovery-oriented. However, they may lack specialist mental health or addictions expertise, which necessitates developing partnerships with the formal mental health system. A third approach is to base a HF team in an inner-city primary care clinic, like the Winnipeg At Home / Chez Soi ACT team and Halifax's MOSH program, which has augmented the HF team with personnel from the formal mental health system, including psychiatry, nursing and rehabilitation support.

Implementation. During the active implementation phase, communities put HF into practice and began providing housing and support to previously homeless people. As implementation proceeded, HF teams moved towards high fidelity practice, and using various means of quality assurance (evaluation, fidelity reviews, etc.) assessed progress towards this goal, and made any necessary adaptations. In this section, we combine *initial implementation* and *full implementation*, since the factors that influenced these two stages were identical.

Barriers to implementation. The main implementation challenges include providing housing choice, rehousing unsuccessful tenancies, adhering to the philosophical principles of the model, providing a comprehensive array of supports, and systemic barriers.

Limits to housing choice. While teams generally practiced the HF model with good fidelity, one particular challenge was providing HF clients with adequate housing choice. This challenge was partly a practical challenge related to housing supply and the strategies for accessing it put in place by the team. As one federal key informant said about the situation in some comunities within and outside of the PHSI project: "[They] don't have affordable housing …[they] don't have dedicated rent sups, [their] vacancy rates are very tight. So, [they] have a lot of concerns right now." The comment relates back to the difficulty communities faced in procuring adequate rent supplements. In some suburban communities (e.g., Fraser, York Region), the difficulty may have been compounded by the relative paucity of the type of housing stock (e.g., apartment blocks) that established HF teams in urban centres drew upon. Communities' lack of experience in knowing how to get potential private sector landlords to participate was also part of this challenge.

Participants suggested that this challenge of providing housing choice was partly attitudinal in nature, relating to past experiences of failure when it came to housing people who had been homeless for a long time, or the idea that "if somebody has been homeless for 10 years, … in fact it's not even right to put them in a situation of their own housing," as one federal key informant put it. Despite the research evidence suggesting one cannot predict housing success, some teams hesitated to risk their limited housing stock on individuals who they perceived not to be ready for their own place. As one key informant put it: "They're deciding 'oh, you're too risky. We're going to put you in this kind of crappy apartment until we see how you do.'" (TTA key informant interview). This strategy, however, carried risks of its own, given that such housing was often in less desirable neighbourhoods and in social contexts that could make it more difficult for individuals to manage their mental health and addictions.

Rehousing. In the HF model, it is expected that for various reasons (e.g., poor fit, stabilization problems, tenancy adjustment issues, etc.) a certain proportion of people will require rehousing. Newer HF teams could struggle with the rehousing process, which could take up resources, and challenge their commitment to rehouse these individuals in a way that respected the model's principles of choice and separation of housing and support. One common challenge was that clients would jeopardize their tenancies by "bringing people in" to their apartments to party or stay for extended periods. In some cases, tenants struggled to set boundaries with unwanted visitors and get them to leave.

During TTA workshops, practitioners often raised the particular challenge of how to successfully house people who had experienced *multiple* rehousings, and questioned whether such individuals were "part of the 15%" of people that the research on HF indicates don't succeed in the traditional, scattered-site HF model, and who required the kind of support that they didn't have access to. As one government key informant put it:

> "There are certain clients that are really high-need, high, high need. And, that you know, case management with a housing support worker isn't going to cut it. It needs to be more of an intensive model. Intensive 24/7 type." (federal government key informant)

Service philosophy. Another fidelity domain teams struggled with was "service philosphy," which despite the name, entails a commitment to the model's principles *as well as* certain skills (e.g., motivational interviewing) related to establishing a therapeutic relationship and, if necessary, encouraging people to make changes to areas (e.g., mental health and addictions) that are getting in the way of their lives. Because of jurisdictional issues, ICM team funding provided by HPS makes it difficult to hire staff (e.g., nurses, social workers) that may possess such clinical skills. Thus, PHSI sites with ICM teams struggled with the "skills" side of the equation. As one TTA key informant said: "They are like nice, young people who are caring, that have the right values. But …they don't have the background" (TTA key informant). On the other hand, communities with ACT teams did have clinicians with those skills, since the ACT model specifies that each team has a psychiatrist, as well as an addictions and illness management specialist. But they could struggle with their style of practice and had difficulty "giving over that control that they've always had as an ACT team." As a key informant summed up, "it's the values *and* practices" (TTA key informant interview). Both are needed.

Service array. The final challenge commonly faced by communities, particularly those who implemented ICM teams, was in providing a comprehensive array of support. While they were typically strong on establishing people in their housing, they tended to be less strong in providing the types of specialized supports (e.g., illness management, addictions and trauma-informed care, etc.) that could help them manage their mental health and addictions. This leads to situations where: "You have ICM workers that are not clinicians working in people's homes with really high acuity individuals" (TTA key informant interview).

Because of the priority given to dealing with crisis situations, HF teams across the board also tended to be less strong on supporting the recovery-related goals of people who had adjusted to coming inside and were now wondering "what now?" and whether they could reconnect with family, go back to school, or pursue some other aspiration.

Systemic barriers. These issues have been addressed in previous sections, so they will not be discussed in detail here. It should be noted, though, that all of the mentioned factors pose a barrier to implementation at the level of the HF team and also hinder community-wide efforts to address chronic homelessness. These include: insufficient affordable housing, lack of policies in support of housing subsidy provision, inflexible service mandates, disparate funding streams, inadequate "system thinking," and insufficient resources for "taking the model to scale."

Implementation facilitators. Through the TTA, including the fidelity assessment visits, the "implementation support system" encouraged the efforts of HF team leaders to adopt certain strategies, including: optimizing housing procurement, becoming more proactive about preventing housing loss, and being more intentional about engagement and recovery. Another implementation strategy was to build on initial successes to improve their practice and take the model to scale.

Optimizing housing procurement. Teams adopted various strategies for becoming better at accessing quality affordable housing of people's choice. In Saskatoon, HPS provided funding for a housing procurement specialist who could help build up the stock of housing for the Journey Home team, as well as for emerging teams in the community. In Fraser and Waterloo, the teams gained access to an increasing supply of rent supplements. Also, teams strived to adopt a common recommendation made by the fidelity team, which was to develop relationships with a

wider base of landlords. As they took risks and experienced initial success, gradually all communities became more comfortable about housing people they previously believed were not "housing ready." As a key informant from the Fraser site said: "There's a conversion process that goes along with practicing the model," noting how clients' success fostered increased belief in the model. As another explained, "I've seen success with people I never would have thought would succeed" (Saskatoon focus group participant).

Becoming more proactive about preventing housing loss. Through the TTA, and over time, teams became more proactive about helping people maintain their housing stability. During the TTA, trainers encouraged teams to work with clients to help them understand the reasons underlying an unsuccessful tenancy. Gradually, they became more adept at identifying common issues (e.g., "bringing people in") and strategizing around contributing factors to these issues, that included social isolation, feelings of obligation to others in one's previous street community, and problems establishing boundaries. For instance, one team developed an agreement where they would play the "bad cop" who would ask unwanted guests to leave. Other teams developed an increased focus on helping people rebuild their previous social networks.

Becoming more intentional regarding engagement and recovery. Challenges with implementing a comprehensive array of supports could lead to problems in early or later implementation. Initially, ICM teams without the requisite clinical supports in particular could experience difficulty engaging clients when they came into housing. Later, once people were stabilized and ready to move on, gaps in supports related to employment and social integration made it challenging to help people move on in their recovery. Through the fidelity visits, and over time, teams developed strategies on both fronts. Regarding engagement, they became more intentional about helping people set recovery goals, which provides a basis for motivational interviewing. They also provided opportunities for staff to build their capacity in both motivational interviewing and trauma-informed care. As well, ICM teams brokered relationships with specialized personnel within the formal mental health and addictions system. In relation to promoting recovery, teams developed strategies, such as forming peer support groups, and became more focused on supporting the needs of people who are ready to move on in their recovery journeys.

As mentioned previously, in order to fill gaps in their service array, ICM teams have found it necessary to develop more formalized relationships with partners who can provide missing resources, particularly in the area of addictions, mental health, and managing chronic health conditions. They also moved away from individual caseloads, and towards working both within their program and with external partners, as "a virtual team."

Reflective practice: Building on success and making adaptations. By engaging in reflective practice, and building on success, teams moved towards high fidelity practice, and towards "taking the model to scale." Reflective practice could entail celebrating individual success stories or carrying out research and evaluation that documented success more systematically. By drawing on such success, teams were able to strengthen various components of their team. For instance, in Waterloo, the results of an evaluation were instrumental in increasing the number of rent supplements provided by the regional government. In Saskatoon, the results of an evaluation that showed reduced costs and service utilization in a number of domains were instrumental in the continued and increased funding for the team. As a result, the team, whose initial goal was to house 22 individuals, has now provided housing and support for over 40 previously homeless individuals.

At the same time, through reflective practice the communities as a whole have learned about areas where adaptations are necessary. The most significant example here is around what has been called the "indigenization" of the Housing First model. Realizing the specific needs and values of Aboriginal clients, teams have adapted such strategies as helping participants connect to cultural practices, hiring Aboriginal team leaders and peer support workers, and have begun using the medicine wheel to guide goal planning. With this in mind, teams have also become more sensitive to respecting housing choice, and realizing that people may be more inclined to choose congregate settings.

Question 5 – How Do Regional Training and Regional Networks Contribute to Housing First Implementation?

Network development was identified as one of the main knowledge transfer strategies for the PHSI project. There were three main aspects of regional networks: (a) regional training, (b) community of practice (CoP) teleconference calls within each region, and (c) the development of regional networks that continue past the end of the MHCC TTA and PHSI projects.

Regional training events. Four regional networking events were coordinated by the MHCC, in the West (primarily BC, given that Alberta already had a network), the Prairies (Saskatchewan, Manitoba, Nunavut, and the northern territories), Ontario, and Atlantic Canada. The aim of the events was to provide training in HF to services providers, particularly for those in communities that had not received training through the MHCC TTA initiative, and to facilitate the creation of regional HF networks that could extend the capacity-building work of the MHCC beyond the TTA period. The agendas for the training sessions typically involved a keynote by Pathways, plenary sessions featuring regional/national experts, a selection of specialized workshops (e.g., service teams, evaluation and policy, peer support, housing procurement, etc.), small and large group sessions focused on planning the next steps in network development, and a workshop on the HF Toolkit.

Evaluations of the regional networking events (see Table 7) suggest that these events may have impacted HF planning and implementation by increasing regional awareness of HF, knowledge about its principles, and readiness to implement the program. The majority of attendees were frontline providers and agency directors who had not participated in previous HF trainings. Regional training evaluations revealed very good ratings for the influence of the training on their overall knowledge of HF (average of 3.7 on a 5-point scale), comprehensiveness (average of 4.0 on a 5-point scale), and overall satisfaction (average of 3.9 on a 5-point scale). The opportunity to learn from other communities was viewed by participants as a benefit.

Table 7

Summary of Key Evaluation Ratings for Regional Networking Events

Sites	Attendance	Number of Evaluation Forms Completed	Influence on Knowledge	Comprehensiveness	Overall Satisfaction
West	150	103	3.5	3.9	3.8
Prairies and Territories	115	54	3.8	3.9	4.0
Atlantic	100	88	3.7	4.0	4.0
Ontario	55	31	3.8	4.1	3.9
Average total / % of all participants who completed an evaluation	105	69 / 66%	3.7	4.0	3.9

*Note: Ratings are on a 1-5 scale with 5 as the most positive rating.

MHCC CoP teleconferences. MHCC teleconferences were held on a monthly to bi-monthly basis in the four regions. The calls were facilitated by MHCC staff members (including members of the TTA team for this project) with agendas including updates from each community and discussion driven by questions raised by local stakeholders around specific aspects of HF implementation. In Ontario, topics during the calls included exchanges of challenges and experiences in preparing for system change within the housing/shelter system, funding models, and the roll out of Registry Week enumeration activities for the 20,000 Homes Campaign spearheaded by CAEH. Stakeholders from London were a particularly notable example of a community that shared critical learnings with others. In the Central CoP (Saskatoon, Winnipeg, Yellowknife) discussions focused on specific aspects of HF implementation, including the use of measures and indicators, ensuring consumers are getting the right level of support, considerations of consumer "flow through" in programs, job descriptions and staff roles in HF, and landlord relations. The Western CoP (Fraser Valley, Nanimo, Kamloops) focused early meetings on considerations of readiness for HF as some communities navigated what HF would look like in their local context and how to begin developing partnerships. Communities farther ahead in the HF implementation process (i.e., Fraser Valley) shared strategies they had found helpful to build readiness. The Eastern CoP (Moncton, Halifax, St. John, Sydney) also provide the opportunity for communities to learn from the experiences of Halifax and Moncton, which had more HF implementation experience than other sites. Discussions focused on topics such as consumer needs assessment, data collection, and effective systems monitoring.

HPS funding was a key topic in all communities, as stakeholders tried to grapple with adapting HF to their communities. The calls also provided an opportunity for communities with more experience with HF to share insights with communities newer to HF with the additional support of the TTA team/CoP facilitators. This facilitated the planning process for communities

at earlier stages of implementation. Discussions focused on nuances of the HF model and participating communities shared tacit knowledge and skills developed through addressing issues arising in the process of implementing HF locally. The extent of community participation on calls was varied. Although there were often a number of communities engaged in the calls, there were times when only one community would be present. In these instances, the calls provided opportunities for consultation with facilitators.

Regional network development. The regional training workshops were also used to create dialogue about and facilitate the initial development of regional HF networks. The majority of stakeholders completing evaluations for the workshops indicated a HF regional network would be of value (86-96% across the four regions). Some stakeholders were unsure of the value (4.5-14%), but no stakeholders indicated a network would not be of value (see Table 8).

Table 8

Perceptions of Whether a Regional HF Network Would Be of Value

Region	% of Attendees Selecting Each Response Option		
	No	Not Sure	Yes
BC/AB (n=23)	0	4.3	95.7
Atlantic (n = 35)	0	14.3	85.7
Prairie (n = 24)	0	4.2	95.8
Ontario (n = 28)	0	7. 1	92.9

During discussions across the regional training workshops, participants identified a number of core considerations of potential regional HF networks. These considerations included network objectives, network composition, and network development.

Network objectives. The overarching purpose of each network was considered to be to enhance the capacity of network members to implement HF. Two main objectives for a potential network emerged from discussions. The first main objective identified was to *promote mutual learning and collaboration* among network members. The network was seen as a strategy to facilitate knowledge exchange through dialogue (e.g., case studies, problem solving, sharing of best practices and lessons learned), coordination of HF TTA opportunities for members (e.g., webinars, site visits), and shared tools and resources (e.g., intake forms, evaluation forms). The second main objective identified was to *support systems and policy change*. Connections developed through a network (e.g., relationships among leaders or communication channels with policy makers and/or government funders) were considered to be of value in supporting the HF planning process, the allocation of resources, and the promotion of increased awareness of HF.

Network composition. Participants considered *strong leadership* to be necessary for the creation of a regional network. The existence of a coordinating body early in network development was suggested as a means of establishing buy-in from communities as well as potential government and cross-sector partners. Shared leadership between grassroots stakeholders and individuals with systems influence was considered important. The CAEH could work with CABs and CEs to provide leadership with involvement of service-providers. Involvement of other national organizations, such as HPS, CMHA, and CMHC was also mentioned. *Open membership*

was another key consideration around network composition. A broad approach to membership was suggested to ensure the networks would be open to stakeholders across sectors with ties to housing supports and efforts to end homelessness. Open membership structures were suggested as a means of engaging multiple stakeholder groups including front line service providers, individuals with lived experience and peer support workers, cross-sector leaders (e.g., health, justice, mental health), government representatives and funders, as well as CABs and CEs.

Network development. The process of network development was generally considered to comprise two key components. The first component was *engagement* to encourage "buy-in" from existing stakeholder groups and begin developing opportunities for connection and discussion to begin establishing the network. The second component was *support*. Participants were asked directly how they felt the leaders of this project (MHCC and project PIs) could support the network development. Participants indicated that support could be best provided in terms of helping to build connections and identifying existing resources (e.g., information resources and research findings, training and support, sources of funding).

In summary, discussions of networks at the regional training events indicated that there was stakeholder support for HF regional networks across Canada. To advance the development of networks, funding for network administration and coordination (e.g., one full-time network coordinator position in each region) would be beneficial to provide the organization and momentum necessary in developing these networks. This coordinator position could be supported by an advisory group of interested parties (e.g., partner organizations, researchers, cross-sector stakeholders).

PHSI researchers have assisted with the development of HF regional networks in Ontario and BC. The idea of HF regional networks was inspired by the success of Alberta's Seven Cities on Housing and Homelessness. Established in 2001 by the seven organizations designated as CEs as a means of navigating the CE role, the activities of the Seven Cities network have evolved over time. In addition to implementing local plans to end homelessness, the Seven Cities work closely with the provincial government to advance Alberta's provincial plan to end homelessness, engage in systems-level planning, and coordinate HF educational opportunities through an annual HF conference and an online HF learning portal for frontline staff.

In Ontario, two of the PHSI researchers successfully applied for staff support from the Evidence Exchange Network (EENet) from 2016-18. The goals of the Ontario Housing First (HF) Regional Network are to: (a) build local capacity for HF programs; (b) expand HF programs across the province; (c) promote high quality implementation of the HF model that includes both fidelity to and adaptation of the model; (d) obtain financial support for HF programs and research; and (e) inform provincial and local housing and support policies for homeless people with mental illness and addictions. The Steering Committee for the Ontario HF Regional Network consists of Ontario HF policy-makers planners, managers, service-providers, researchers, and persons with lived experience, including representatives from the housing, health, and justice sectors and Aboriginal programs. Key partners include CAEH, the Homeless Hub, and HPS.

The Ontario HF Network has a website, http://eenet.ca/initiative/housing-first-community-interest#about, has held webinars on rent assistance and the HPS Housing First portal, and has a roster of HF TTA consultants and researchers. It is currently developing an inventory of HF pro-

grams in Ontario, planning further webinars and a provincial HF forum, and creating a policy brief for the provincial government on housing allowances.

In BC, two of the PHSI researchers have consulted with BC CE staff and assisted them with the creation of the BC 10. The BC 10 is in the early stages of development, but has regular conference calls and has involved BC Housing in its work.

Discussions about regional networks have also been held with HF stakeholders in the Atlantic provinces (Nova Scotia, New Brunswick, Newfoundland, and Prince Edward Island) and the Prairie provinces (Manitoba and Saskatchewan).

Summary and Conclusions

This study demonstrated that, over a three-year period, six communities were successful in implementing new and/or enhanced HF programs. Through changes in federal homelessness policy and funding, TTA, and regional networks, diverse communities were able to overcome implementation barriers and facilitate the implementation of relatively high fidelity HF programs. This research demonstrates the value of both policy change and TTA tailored to each community to make change in the local service delivery system.

Given the limitations in existing resources, communities exhibited strong leadership and innovation in achieving such high-fidelity implementation, in a context requiring multiple changes, including a shifted mandate (chronic homelessness), new ways of making decisions (mandate vs. consensus driven), and new ways of allocating resources (oriented towards establishing a system of care vs. program-driven). Throughout, community champions played an integral role in moving implementation forward, and navigating change within this new context, by helping to establish a common vision, bringing in necessary resources, and drawing in well-suited agencies to deliver the model. Similarly, the TTA provided strong support, particularly with programmatic aspects of HF implementation, in terms of helping communities understand the HF model, and providing the practical support to implement it with fidelity to the model.

Moving forward, communities require continued implementation support with systemic issues such as coordinated entry, and guidance around effective assessment tools, including the VAT (Vulnerability Assessment Tool), that are sensitive to the needs of people experiencing chronic homelessness. Communities also require support to help them address the issue of sustainability. Through evaluation, some participating communities had begun to demonstrate improved participant outcomes. By continuing to demonstrate improvements in the lives of people experiencing chronic homelessness as well as system efficiencies, communities can solidify and build their programs in the future.

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APPENDIX A

DATA COLLECTION SOURCES

Table 1

Number of Participants in Needs Assessment for Housing First Training

Site	Interview	Number of Participants
Fraser	Focus Group 1	10
	Focus Group 2	8
Saskatoon	Focus Group 1	8
	Focus Group 2	7
Winnipeg	Focus Group 1	4
	Individual	1
Waterloo	Focus Group 1	13
Toronto	Focus Group 1	4
	Focus Group 2	5
	Individual	1
Montreal	Focus Group 1	3
Halifax	Focus Group 1	4
	Focus Group 2	11
	Individual	4
Total		83

Table 2

Summary of Participants for Initial Site Training Workshops

Sites	Attendance	Number of Evaluations Completed
Fraser	50	43
Saskatoon	47	38
Winnipeg	110	82
Waterloo	155	112
York	62	27
Average / total	85 / 424	60 / 302

Table 3

Summary of Participants for Follow-up Site Training Workshops

Sites	Attendance	Number of Evaluations Completed
Fraser (two follow-up trainings)	101	17
	35	18
Saskatoon (two follow-up trainings)	35	16
	30	11
Winnipeg	100	26
Waterloo	50	39
York	40	19
Halifax	10	8
Average / total	50 / 401	19 / 154

Table 4

Summary of Participants for Regional Network Training Events

Sites	Attendance	Number of Evaluation Forms Completed
West	150	103
Prairies and Territories	115	54
Ontario	55	31
Atlantic	100	88
Average / total	105 / 420	69 / 276

Table 5

Number of Housing First Programs for Which Fidelity Assessments Were Completed

Sites	Number of Fidelity Assessments Completed
Fraser	4
Saskatoon	1
Winnipeg	2
Waterloo	1
York	1
Halifax	1
Total	10

Table 6

Number of Participants for Final Interviews

Site	Interview	Number of Participants
Fraser	Focus Group	4
Saskatoon	Focus Group	4
Winnipeg	Focus Group	4
Waterloo	Focus Group	4
York	Focus Group	6
Halifax	Focus Group	4
	Individual	3
TTA staff	Individual	2
HPS staff	Focus Group	4
Total		35

Table 7

Field Note Entries for Project Sites and Regional Networks (2013-2016)

Site	Number of Field Note Entries
Fraser	19
Saskatoon	10
Winnipeg	14
Waterloo	13
Toronto	9
York	7
Montreal	1
Halifax	16
West Region	16
Prairies and Territories Region	11
Ontario Region	15
Atlantic Region	6
National	9
Total	146

APPENDIX B

DATA COLLECTION PROTOCOLS

TRAINING NEEDS ASSESSMENT FOCUS GROUP PROTOCOL

After completing the consent form, researcher says: "We are now going to begin the focus group. Please respect everyone's privacy by not discussing anything said during this session with anyone outside of the focus group. I'm now turning the audio recorder on".

The following questions will guide our focus group discussion which will be about the planning, implementation and operation of a Housing First program in your community.

1. What led you (and who led you) to choose to implement a Housing First program?

- Probe: What role did homeless policy, community leaders, research evidence, or other factors play in your decision?

2. Who are the partners that are now involved in the implementation or who are the partners that you would want to be involved in your implementation?

3. How do you envision your implementation efforts? Will the program be a new start up by a single agency or a partnership among multiple agencies collaborating to provide the housing and community based support services? Describe the role of each partner?

- Probe: What role and what resources will each partner or entity contribute to implementation efforts?

4. Would you need any education, consultation, or technical assistance to develop or enhance your project if it was available? In what areas would you like to have education, consultation and technical assistance?

5. As you move from implementation to operation, what kinds of education, consultation or technical assistance would you require?

6. If you choose to, you can have key members of your team participate in a community of practice for Housing First programs, they would members of a regional and national community of practice (CoP) that will obtain and provide on-going consultation and peer support for your housing first project. Is this of interest to your group? What kinds of resources and relationships would you envision being able to draw upon within these CoPs

- Probe: What kinds of infrastructure would you envision as being necessary for sustaining national and regional CoP's?

2. Is there anything else that you would like address or to add or do you have any questions?

I'm now turning the audio recorder off.

SAMPLE TRAINING AND TECHNICAL ASSISTANCE WORKSHOP EVALUATION FORMS FOR SITES

Transforming Treatment Services and Housing for People with Mental Illness in Canada: Initial Training Workshop Evaluation

Thank you for your participation in the workshop. To help us in ensuring the workshops are engaging and informative, we are asking you to complete this brief evaluation before the workshop begins. This evaluation is a part of a study by Geoff Nelson of Wilfrid Laurier, and Paula Goering and Vicky Stergiopoulos of University of Toronto. These researchers are examining the effectiveness of the knowledge exchange process of a study funded by the Canadian Institutes of Health Research.

Self-Generated ID Number ____-____

I. Background Information

1. **Where did you participate in the workshop?**
a. City/Town _____ b. Province_____

2. **From what primary perspective are you attending workshop? (Please check one)**
☐ Community Member ☐Service delivery agency director/administrator ☐ Direct service provider
☐ Government/policy maker ☐ Volunteer

3. **How did you first hear about the workshop?**
☐ Flyer ☐ Word of mouth
☐Other_____

4. **Are you involved in providing supports for people with mental illness who have been homeless?**

☐ Yes ☐ No

5. **If Yes, how long have you been involved in housing supports?**
_____years as a volunteer _____years of employment

6. **If you are affiliated with a community organization (employee, volunteer, etc.)**
a. Name of organization
_____

b. What type of organization are you affiliated with?

☐ mental health treatment/support ☐ homelessness/housing agency ☐ income support ☐police/justice system

☐ Other (Please specify):_____

7. **What is your primary language?**

☐ English ☐ French ☐ Other (Please specify):_____

The questions immediately below are included solely to gather general demographic information of workshop participants.

8. **Age**	9. **Gender**	10. **Race/Ethnicity**
☐ 16 – 24	☐ Male	☐ White or Caucasian
☐ 25 – 54	☐ Female	☐ Black or African Descent
☐ 55 +	☐ Other	☐ Aboriginal First Nations/Metis/Inuit
☐ Decline to Answer	☐ Decline to Answer	☐ Asian or Pacific Descent
		☐ Hispanic or Latino/a
		☐ Other_____
		☐ Decline to Answer

11. **What did you hope to get out of the workshop?**

II. Prior Knowledge of Housing First

1. For what purposes do you intend to seek more information about HF? (Check all that apply)

☐ To advocate for the development of new programs
☐ To explore the feasibility of implementing a new program
☐ To plan a new prevention program
☐ To improve or change an existing community program
☐ To explore new approaches and perspectives to homelessness/treatment services for people with mental illness
☐ To share approaches with other stakeholders
☐ Other (please specify):_____

2. Prior to receiving an invitation to this workshop, were you aware of Housing First?

☐ Yes ☐ No

3. If you were aware of Housing First prior to receiving an invitation to this workshop, how long have you been aware of it?

☐ less than a year ☐ between 1 and 5 years ☐Over 5 years

4. If you were aware of Housing First prior to receiving an invitation to this workshop, what was your impression of the Housing First program, and about how to implement it, prior to attending this workshop?

_____

_____

_____

_____

_____

5. Please rate the following statements regarding the need for transformative change in relation to treatment services & housing for people with direct experience of homelessness and mental illness in your community:

	Not at all	Slightly	Moderately	Very	Extremely
a. It needs to be done.	1	2	3	4	5
b. The reasons are clear.	1	2	3	4	5
c. I want to participate.	1	2	3	4	5
d. I have the abilities to contribute.	1	2	3	4	5
e. I am well prepared to participate.	1	2	3	4	5
f. I am committed to making changes.	1	2	3	4	5
g. I have begun taking steps.	1	2	3	4	5

III. Workshop

1. To what extent were the following workshop components helpful in gaining a better understanding of Housing First:

	Very Low	Low	Moderate	High	Very High
a. Presentation	1	2	3	4	5
b. Video/Stories	1	2	3	4	5
c. Discussion	1	2	3	4	5

2. To what extent did you feel the information presented was comprehensive?

Very Low	Low	Moderate	High	Very High
1	2	3	4	5

3. Were there any topics you feel were missing? If so, please list.

_____

_____

4. Have your impressions about HF and how to implement it changed? (Please share any thoughts or comments)

5. What is your overall level of satisfaction with the workshop?

Very Low	Low	Moderate	High	Very High
1	2	3	4	5

6. How could the workshop be improved in the future?

6. Do you have any additional feedback or comments?

THANK YOU FOR COMPLETING THIS EVALUATION FORM!

Transforming Treatment Services and Housing for People with Mental Illness in Canada: Follow-up Training Evaluation Form

Thank you for your participation in this training. To help us ensure that the training workshops are engaging and present relevant information, we are asking you to complete this brief evaluation before the workshop begins. This evaluation is a part of a study by Geoff Nelson of Wilfrid Laurier, and Paula Goering and Vicky Stergiopoulos of the University of Toronto. This study aims to examine the effectiveness of the knowledge exchange process in disseminating evidence on housing and mental illness in Canada. This study is funded by the Canadian Institutes of Health Research.

Please complete Section I before the training workshop begins.

I. Background Information

1. **Where did you participate in the workshop?**
a. City/Town _____ b. Province_____

2. **From what primary perspective are you attending workshop? (Please check one)**
☐ Community Member ☐Service delivery agency director/administrator ☐ Direct service provider
☐ Government/policy maker ☐ Volunteer

3. **How did you first hear about the workshop?**
☐ Flyer ☐ Word of mouth ☐Other_____

4. **Are you involved in providing supports for people with mental illness who have been homeless?**
☐ Yes ☐ No

5. **If Yes, how long have you been involved in housing supports?**
_____years as a volunteer _____years of employment

6. **If you are affiliated with a community organization (employee, volunteer, etc.)**
a. Name of organization _____

b. What type of organization are you affiliated with?

☐ mental health treatment/support ☐ shelter/housing agency
☐ income support ☐police/justice system
☐ Other (Please specify):_____

7. **What is your primary language?**
☐ English ☐ French ☐ Other (Please specify):_____

The questions immediately below are included solely to gather general demographic information of workshop participants.

8. **Age**	9. **Gender**	10. **Race/Ethnicity**
☐ 16 – 24	☐ Male	☐ White or Caucasian
☐ 25 – 54	☐ Female	☐ Black or African Descent
☐ 55 +	☐ Other	☐ Aboriginal First Nations/Metis/Inuit
☐ Decline to Answer	☐ Decline to Answer	☐ Asian or Pacific Descent
		☐ Hispanic or Latino/a
		☐ Other_____
		☐ Decline to Answer

11. **What do you hope to get out of the workshop?**

12. **Did you participate in an earlier Housing First training workshop?**

☐ Yes ☐ No**.**

THANK YOU FOR COMPLETING THIS PART OF THE EVALUATION FORM! RELAX AND HAVE A COFFEE BEFORE THE WORKSHOP BEGINS!

PLEASE COMPLETE THE FOLLOWING SECTIONS AT THE END OF THE WORKSHOP.

1. To what extent were the following workshop components helpful in gaining a better understanding of Housing First:

	Very Low	Low	Moderate	High	Very High
a. Housing First team operations	1	2	3	4	5
b. Housing First program operations	1	2	3	4	5
c. Case presentation and discussion	1	2	3	4	5
d. Question and answer session	1	2	3	4	5

2. To what extent did you feel the information presented was comprehensive?

Very Low	Low	Moderate	High	Very High
1	2	3	4	5

3. Have your impressions about HF and how to implement it changed? Please share any thoughts or comments.

_____

_____

_____

_____

4. Were there any topics you feel were missing? If so, please list.

_____

_____

_____

5. What is your overall level of satisfaction with the workshop?

Very Low	Low	Moderate	High	Very High
1	2	3	4	5

6. How could the workshop be improved in the future?

7. What was the most helpful aspect of this training?

8. What was the least helpful or useful aspect of this training?

9. In the future, what other training, supports or resources would be helpful to you as you continue your work in Housing First?

11. Do you have any additional feedback or comments?

THANK YOU FOR COMPLETING THIS EVALUATION FORM!

SAMPLE TRAINING AND TECHNICAL ASSISTANCE WORKSHOP EVALUATIONS FOR REGIONS

Transforming Treatment Services and Housing for People with Mental Illness in Canada: Regional Training Evaluation Form Fraser Health, May 28, 2015

Thank you for your participation in this training. To help us ensure that the training workshops are engaging and present relevant information, we are asking you to complete this brief evaluation before the workshop begins. This evaluation is a part of a study by Geoff Nelson of Wilfrid Laurier, and Paula Goering and Vicky Stergiopoulos of the University of Toronto. This study aims to examine the effectiveness of the knowledge exchange process in disseminating evidence on housing and mental illness in Canada. This study is funded by the Canadian Institutes of Health Research.

Please complete Section I before the training workshop begins.

I. Background Information

1. **Where did you participate in the workshop?**
a. City/Town _____ b. Province_____

2. **From what primary perspective are you attending workshop? (Please check one)**
☐ Community Member ☐Service delivery agency director/administrator ☐ Direct service provider
☐ Government/policy maker ☐ Volunteer

3. **How did you first hear about the workshop?**
☐ Flyer ☐ Word of mouth
☐Other_____

4. **Are you involved in providing supports for people with mental illness who have been homeless?**

☐ Yes ☐ No

5. **If Yes, how long have you been involved in housing supports?**
_____years as a volunteer _____years of employment

6. **If you are affiliated with a community organization (employee, volunteer, etc.)**
a. Name of organization
_____

b. What type of organization are you affiliated with?

☐ mental health treatment/support ☐ shelter/housing agency ☐ income support ☐police/justice system

☐ Other (Please specify):_____

7. **What is your primary language?**
☐ English ☐ French ☐ Other (Please specify):_____

The questions immediately below are included solely to gather general demographic information of workshop participants.

8. **Age**	9. **Gender**	10. **Race/Ethnicity**
☐ 16 – 24	☐ Male	☐ White or Caucasian
☐ 25 – 54	☐ Female	☐ Black or African Descent
☐ 55 +	☐ Other	☐ Aboriginal First Nations/Metis/Inuit
☐ Decline to Answer	☐ Decline to Answer	☐ Asian or Pacific Descent
		☐ Hispanic or Latino/a
		☐ Other_____
		☐ Decline to Answer

11. **What do you hope to get out of the workshop?**

12. **Did you participate in an earlier Housing First training workshop?**

☐ Yes ☐ No.

THANK YOU FOR COMPLETING THIS PART OF THE EVALUATION FORM! RELAX AND HAVE A COFFEE BEFORE THE WORKSHOP BEGINS!

PLEASE COMPLETE THE FOLLOWING SECTIONS AT THE END OF THE WORKSHOPS.

Morning Sessions

1. To what extent were the following workshop components helpful in gaining a better understanding of Housing First:

	Very Low	Low	Moderate	High	Very High
a. Presentation HF 101	1	2	3	4	5
b. Presentation PWLE	1	2	3	4	5
c. Scenarios & discussion	1	2	3	4	5

Afternoon Sessions

2. To what extent were the following workshop components helpful in gaining a better understanding of Housing First implementation:

	Very Low	Low	Moderate	High	Very High
a. Presentation HF Overview & Dialogue	1	2	3	4	5
b. Building interagency partnerships	1	2	3	4	5

3. To what extent did you feel the information presented was comprehensive?

Very Low	Low	Moderate	High	Very High
1	2	3	4	5

4. Have your impressions about HF and how to implement it changed? Please share any thoughts or comments.

5. Were there any topics you feel were missing? If so, please list.

_____

_____

_____

6. What is your overall level of satisfaction with the workshops?

Very Low	Low	Moderate	High	Very High
1	2	3	4	5

7. How could the workshops be improved in the future?

_____

_____

_____

8. What was the <u>most</u> helpful aspect of this training?

_____

_____

_____

9. What was the <u>least</u> helpful or useful aspect of this training?

_____

_____

_____

10. Do you have any additional feedback or comments?

_____

_____

_____

THANK YOU FOR COMPLETING THIS EVALUATION FORM!

CAEH Training & Technical Assistance

LEARN THE TOOLS & STRATEGIES TO IMPLEMENT CHANGE LOCALLY

PHF-ICM Fidelity Interview Guide

Pathways Housing First

Date of Interview:	

Community Being Reviewed:		Program Being Reviewed:	
Name of Interviewee:		Position/Job Title:	

Role on Team
Could you describe your role on the team?

HOUSING
Housing Process & Move-in Support
What happens after someone is enrolled in your program?

Tell us about the housing process (how is it decided where participants will live)?

What kind of housing support does the program provide when someone is moving in?

Are there any changes that have been made in the housing process in the past year?

Readiness Requirements
What requirements do participants have to meet in order to gain access to apartments?

- ***Are there things that aren't requirements, but the team would prefer to have in place prior to moving someone into an apartment?***

- ***Does the team have concerns about housing participants who are refusing psychiatric medication or who are still using alcohol or drugs?***

- ***Does the program ever place participants in transitional housing first to assess their ability to live on their own?***

Rapid Housing Placement & Barriers

In the past year, how long does it usually take participants to go from program intake to move-in?

What are some of the challenges in placing participants into housing quickly?

Working with Landlords

How are relationships with landlords?

- ***What have been some strategies that the program has used to maintain positive relationships with landlords?***

- ***What have been some of the challenges?***

- ***Does the program still set limits on the number of apartments you will rent in any one building***

- ***What are the most common landlord complaints?***

- ***Have you moved individuals in order to avoid eviction? How common is this practice?***

- ***Has anyone been formally evicted?***

Tenant Leases

What do the tenant leases look like?

- ***Are there any special provisions added to the lease or occupancy agreement?***

- ***How does the program address these?***

Can you tell us about some of the participants not currently living in scatter-site apartments?

- ***Where are they living & how was this decided?***

<u>On-going Requirements & Housing Support</u>
What kind of housing support does the program provide on an on-going basis?

What requirements do program participants have to meet in order to stay in their apartments?

<u>Re-housing Process</u>
What happens when a participant loses his or her housing?

- ***How is the re-housing process different from the initial housing placement?***

- ***How is it decided where the participant will move?***

- ***Is there a written protocol for re-housing procedures?***

- ***What requirements do program participants have to meet in order to be able to move into another apartment? What happens if they fail to meet these requirements?***

<u>Discharge</u>
What are some of the reasons that participants have been discharged from the program?

<u>Housing-Clinical Roles</u>
Is the ICM team responsible for Housing or are these services brokered out to a Housing Team?

How clear are the respective roles between housing and clinical services?

How is this separation communicated/acted out to clients?

SERVICES

Goals

How does the program decide what goals to work on with participants?

- ***Participant input?***

- ***Are there any standardized goals that are included in treatment plans? What is the role of these goals?***

How have goals changed over time?

Assertive Engagement

How does the program work with participants who have disengaged?

- ***What techniques do you use with participants who start refusing services or refusing to see staff? Can you give us some examples?***

Participant choice & independence

How do you determine the level of support that you provide to participants?

- ***Does this change over time? What determines this change?***

What happens when the program and the participant disagree about the degree to which the team is involved in their life?

Substance Use & Harm Reduction

What type of substance abuse services do participants have access to?

- ***What is the referral process?***

- ***How are participants assessed to match needs and preferences to providers?***

- ***What is the nature of coordinating care between your program and providers of substance abuse services?***

How does the program approach participants when they are concerned about their substance use?

- ***Can you give us examples of any harm reduction techniques?***

<u>Mental Health & Psychiatric Services</u>
How does the program approach participants who are actively experiencing psychiatric symptoms and refusing medication?

- ***What type of treatment support is available for psychiatric symptoms?***

- ***What is the role of the psychiatrist? (assessments, medication monitoring, home visits)***

- ***What is the nature of coordinating care between your program and mental health and psychiatric providers?***

What role does program staff play when a participants is admitted to inpatient treatment?

- ***Whose responsibility is it to coordinate admission, treatment, and discharge with the inpatient staff?***

<u>Coercion</u>
Does the program use any of the following activities to promote participation in the program or treatment adherence?

- ***Any mandating daily visits, urine screening, monetary incentives for medication, caution withholding services, housing, or income, engaging in quid pro quo***

- ***How do staff feel about these activities?***

<u>Motivation Interviewing</u>
Are team members familiar with motivational interviewing?

- ***Can you give us some examples of how you've used MI?***

- ***How frequently do you use MI techniques?***

Service Array
What life areas does the program target/broker out services to?

- ***Are there some areas that the program focuses more so on than others?***

Nursing Services
What nursing services are available to participants?

- ***Manage medication, screen for medical problems & side-effects, coordinate with other providers, health promotion & disease prevention?***

- ***What is the nature of coordinating care between your program and providers nursing services?***

Educational & Employment Services
How does the program address educational and vocational needs?

- ***Are participants routinely assessed for their interest in school or work?***

- ***What is the extent of coordinated care between your program and educational and employment services?***

Social Integration Services
Can you tell me about the kinds of services that the team either provides or brokers in terms of helping participants engage in social activities?

- ***Develop roles outside the program, help with negotiating social relationships, enhancing citizenship activities?***

24-hr. Coverage
What happens if a participant experiences a crisis after office hours?

Mobile Services

How is it decided where you will meet with participants?

- ***How much time is spent delivering services in the office vs. in the community?***

INTERVIEW PROTOCOLS FOR STAKEHOLDERS AT PROJECT END

Focus Group Interview Guide to Assess the Impacts of IKT Activities on Project-Specific Partners

After reviewing the information letter and consent form, the researcher says:

"We are now going to begin the focus group. Please respect everyone's privacy by not discussing anything said during this session with anyone outside of the focus group. I'm now turning the audio recorder on."

The following questions will guide our focus group discussion that will be about your thoughts and experiences about how Housing First has been implemented in your community and how it can continue to be expanded.

Partnership and Shared Vision for Housing First

1) Who were the partners? Please describe any previous working relationships among the partners regarding Housing First or other housing or health initiatives.

2) To what extent is there a shared vision for Housing First in your community? If so, how did community partners come together to create a shared vision for the implementation of Housing First in your community?

3) What helped the most in the development of a shared vision among community partners? What were (or continue to be) the most significant barriers to creating such a vision?

4) How or to what extent have you adapted the Housing First model to the local context (e.g. needs, values, practices or "ways of doing things")? What if any have been the challenges balancing local "ways of doing things" with fidelity to the Housing First model?

Training and Technical Assistance

5) How, if at all, has the knowledge you have gained through the training and technical assistance provided by the Mental Health Commission of Canada (via Pathways and the PHSI project) helped you to implement the Housing First model?

6) What aspects of the training and technical assistance have been particularly helpful? (remind them of different aspects, e.g. site-specific and regional training events, check-in consultations, CoP calls, etc.)

7) What aspects have been unhelpful or were missing?

8) Were you able to use or adapt the material from the training and technical assis-

tance to meet your needs? How so?

9) What role did the fidelity visit and assessment play in assisting your community with Housing First implementation?

Systems-level Barriers and Facilitators of Implementation

10) What systems-level barriers impeded the implementation of Housing First? How were these barriers overcome or reduced?
Probe re: practitioner factors (including congregate housing providers), organizational-level factors, and broader systems-level factors

11) What systems-level factors helped with the implementation of Housing First?
Probe re: practitioner factors, organizational-level factors, and broader systems-level factors

Systems Transformation

12) How or to what extent have your implementation efforts led to a transformation of existing services in your community?

13) How or to what extent have your implementation efforts led to a transformation of policy in your jurisdiction?

14) What do you think it will take for further transformation to occur so that Housing First is expanded in your community?

Before we end this focus group, I want to ask if anyone has any additional point that they would like to make about the implementation of Housing First in your community.

Thank you for your time participating in this focus group today.

Interview Guide for Members of the Training and Technical Assistance Team

After reviewing the information letter and consent form, the researcher says:

"In the interview, I want you to focus your answers on the PHSI communities (Surrey, Edmonton, Winnipeg, Waterloo, York, Halifax), unless I indicate otherwise. We are now going to begin the interview. I'm now turning the audio recorder on."

Partnership and Shared Vision for Housing First

1) Implementing Housing First in communities requires people to make partnerships and develop a shared vision for Housing First as a strategy to end chronic homelessness. From your experience with the training and technical assistance, how successful were the communities in partnership-building for Housing First?

   In your view, what was most important for the development of a shared vision among community partners? What were the most significant barriers to creating such a vision? Probe re: opposition from congregate housing providers

2) In your view, how successful were the communities in adapting the Housing First model to the local context, while maintaining fidelity to the model?

Training and Technical Assistance

3) In your opinion, what worked well in the training and technical assistance program?

4) Were there particular aspects of the training and technical assistance program that were critically important to implementation? If so, what were they? Also, was there anything that in retrospect you would have seen as useful to add?

5) What role did the fidelity visits and assessments play in assisting communities to implement Housing First?

6) In your view, which communities were most successful in implementing Housing First and what differentiated from the more successful from the less successful communities?

Systems-level Barriers and Facilitators of Implementation

7) What systems-level barriers impeded the implementation of Housing First? How were communities able to overcome or reduce these barriers?
   Probe re: practitioner factors, organizational-level factors, and broader systems-level factors

8) What systems-level factors helped with the implementation of Housing First? Probe re: practitioner factors, organizational-level factors, and broader systems-level factors

Systems Transformation

9) How or to what extent have the communities been able to transform their existing services?

10) How or to what extent have the communities been able to transform their existing policies?

11) What do you think it will take for further transformation to occur so that Housing First is expanded across Canada?

Before we end this interview, I want to ask if you have any additional points that you would like to make about the training and technical assistance program and the implementation of Housing First in Canadian communities.

Thank you for your time participating in this interview today.

TRACKING FORM FOR FIELD NOTES

Date(s):

Site:

Method of Contact:

In Person:	_____
Phone:	_____
Email:	_____

Location of Activity (if in person):

Level of Activity:

National Network:	_____
Regional Network:	_____
Site-specific Partner:	_____ (specify which site)
Government Policy-makers:	_____ (specify which policy-makers)
Other:	_____ (specify)

PHSI Team Member(s) Involved: provide names for each category

Research Team Member(s):

Decision-maker(s):

Consultant(s):

Stakeholder(s)

Local Leaders and Advocates:	Yes _____ No _____
Health Authorities:	Yes _____ No _____
Mental Health Service-providers:	Yes _____ No _____
People with Lived Experience:	Yes _____ No _____
Housing Sector:	Yes _____ No _____
Income Assistance:	Yes _____ No _____
Police or Criminal Justice:	Yes _____ No _____
Funding Bodies:	Yes _____ No _____
Regional Government:	Yes _____ No _____
Municipal Government:	Yes _____ No _____
Business Community:	Yes _____ No _____
Other: Landlords	Yes _____No _____

Approximate Time Involved in Activity:

Less than 2 hours _____
Roughly half a day _____
Full day _____
More than a day _____

Type of Activity:

Preparing for a Meeting _____
Education/Training/Information _____
Partnership-building _____
Networking _____
Consultation/Technical Assistance _____
Research/Data Gathering _____
HF Planning _____
HF Implementation _____
HF Funding _____
Infrastructure Development _____
Other (specify) _____

Attachment any Supplementary Documents (e.g., minutes of meetings) to this Form

Short Statement of Purpose of Activity:

Short Statement of What Was Done:

Reflections from PHSI Team Member on the Following (*refer to PHSI Factors Facilitating Readiness doc for definitions of below terms – can be found in Tracking Form/Protocol File in PHSI dropbox*):

Characteristics/Capacity:

Organizational Capacity:

Characteristics of the Intervention:

Community Capacity:

Planning Capacity (including local planning and MHCC training and technical assistance):

Next Steps/Implications: