The At Home/Chez Soí Project:

Year Two Project Implementation at the Vancouver, BC Site

Prepared by:
Michelle Patterson, PhD, RPsych
Simon Fraser University
Faculty of Health Sciences
May 2012

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Partners and Collaborators

Researchers:

Providence Healthcare
Simon Fraser University
University of British Columbia

Project Service Providers:

Coast Foundation
Motivation, Power & Achievement (MPA) Society
Portland Hotel Community Services Society (PHS)
RainCity Housing

Community Stakeholders:

BC Housing
BC Ministry of Health Services
BC Ministry of Social Development
City of Vancouver
Providence Health Care/St. Paul's Hospital
Street to Home Foundation
Vancouver Coastal Health
Vancouver Foundation

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Introduction

Over the past 30 years, homelessness has emerged as a significant social problem across Canada, growing in both size and scope in urban, semi-urban and rural communities (Laird, 2007). Homeless adults suffer disproportionately from high rates of serious mental health and substance use problems compared to the general population. Further, co-occurring physical health problems are also very common (see Frankish, Hwang & Quantz, 2005). Although individuals with mental disorders constitute a minority of the homeless population, research has shown that they are more likely to experience repeated episodes and longer periods of homelessness as well as require more health and social services than homeless individuals without mental disorders.

Among other structural changes, the growth in the rate of homelessness has coincided with the deinstitutionalization of long-stay psychiatric institutions across North America. This significant downsizing in psychiatric care has been accompanied by inadequate investments in the expansion and integration of community programs that provide services for individuals with mental and substance use disorders as well as welfare, criminal justice, and housing services. As a result, many cities across Canada, including Vancouver, have witnessed a significant increase in the number of homeless individuals with serious mental disorders (including substance use disorders) that have not only diverse housing and mental health-related needs, but needs that are complicated by physical health problems, trauma, and various social and occupational challenges.

While the research literature presents a complex relationship between homelessness and mental health, it is clear that untreated psychiatric and physical health conditions contribute to chronic homelessness. However, the services designed to address various psychiatric, substance use, physical health and social issues are often segregated and inadequate. Mental disorders and substance use disorders are most often addressed by diverse community-based non-profit organizations while physical health conditions tend to be treated in walk-in clinics and Emergency Departments where continuity of follow-up care is limited. Community mental health teams and non-profit agencies are often ill-equipped or under-resourced to address the multiple needs of individuals with complex and concurrent needs, which often leads to incomplete care and further unmet need. Given the high rates of behavioural and physical health problems among homeless individuals and the inadequacy of services, there is a growing need for effective approaches that integrate housing with treatment and support services (Rosenheck et al., 2003).

A growing body of research demonstrates that supported housing has a positive impact on residential stability, regardless of the specific model of housing (Best, 2006; Rog, 2004). Recent research indicates that a Housing First approach, which provides permanent, independent housing that is dispersed throughout the community, is an effective approach for people who are homeless with mental disorders, including substance use (e.g., Tsemberis & Eisenberg, 2000). This model places no treatment demands on clients but offers intensive support services to help individuals integrate into their community. Despite these findings, the impact of

supported housing on outcomes other than those related to residential stability and hospitalization have not been thoroughly examined, and existing studies have not yielded consistent results.

Evidence is emerging to suggest the characteristics of effective interventions for homeless individuals with psychiatric symptoms, including the importance of perceived choice (Greenwood et al., 2005; Nelson et al., 2007). *Assertive Community Treatment (ACT)* is a model of care for people with severe mental illness in which a multidisciplinary team provides treatment and rehabilitation in addition to case management functions. An extensive body of research has shown that ACT is effective in reducing hospitalization and improving symptoms of mental illness as well as social functioning (see Ziguras & Stuart, 2000). *Intensive Case Management (ICM)* is another model of care for people with mental illness in which services are brokered to community agencies by a case manager rather than delivered by a team (as in ACT). The evidence base for ICM is not as strong as that for ACT. However, ICM has been shown to be effective in improving symptoms of mental illness as well as social functioning (see Dixon & Goldman, 2003). Despite the body of evidence in favour of ACT and, to a lesser degree, ICM, little is known about the effectiveness of different intensities of intervention for homeless individuals with differing levels of need.

In addition to the increase in homelessness and diverse service needs, many cities face a substantial shortage in the availability of affordable housing units. In light of limits to housing availability, the implementation of scattered-site housing may not offer the most efficient use of available service resources. Alternative strategies, including approaches that provide independent housing of homeless persons with severe mental illness in *congregate* settings where neighbors would include other persons with severe mental illness, have not been adequately explored (see He, O'Flaherty & Rosenheck, 2010; Walker & Seasons, 2002). Further, given the current economic recession, exploring the relative advantages and disadvantages of congregate housing arrangements on persons with severe mental disorders is timely.

Over the past decades, a movement toward evidence-based practice has emerged in medicine and, more recently, in public health (see Des Jerlais et al., 2004). The randomized controlled trial (RCT) is usually seen as the strongest method for assessing the efficacy of interventions. Health Canada and the Mental Health Commission of Canada, the funding bodies for the At Home Project, predetermined that an RCT would be the underlying design of the study, implicitly supporting the movement toward complex policy trials and multi-site RCTs as primary methods for developing policy-related knowledge. Given these decisions, certain constraints, such as random assignment to intervention and control groups as well as the lack of a clear sustainability plan, were inherent in the basic study design.

Given the growth in both the size and scope of homeless populations and the increasing need for effective approaches that integrate housing with mental health and support services, as well as limitations in the research literature, obtaining a better understanding of how supported housing and services influence the broader context of individuals' lives is critical. An improved

knowledge surrounding homelessness and the service needs of individuals is necessary for the development of not only long-term, community-based solutions, but for the formation of well-defined health and social policy.

Purpose

This report follows an earlier report (Schmidt & Patterson, 2011) which examined how the Vancouver site mobilized research, housing, and service provider teams to recruit, house and support participants in the first year of project implementation (October 2009 to January 2011). The current report documents the implementation of the Vancouver At Home housing and support interventions in the second year of project implementation, including the second round of intervention fidelity assessments. It describes the continuing and emerging strengths and challenges faced by the housing and intervention teams as they implemented their programs from January 2011 to January 2012.

More specifically, this report focuses on the following:

- Year two fidelity assessments
- Continuing and emerging strengths and challenges
- Housing and re-housing issues
- Facilitators and barriers to housing and recovery
- Involvement of people with lived experience
- Engagement of landlords and building managers

Local Context

In Vancouver, the overlap between mental disorders, substance use, and homelessness has become a civic crisis. When compared to the rest of British Columbia and Canada, Vancouver is unique in terms of the heterogeneity, multi-morbidity and concentration of its homeless population. The extent of chronic medical conditions, including infectious disease, has been well-documented among Vancouver's homeless population (Acorn, 1993; Wood, Kerr et al., 2003). Furthermore, many homeless individuals in Vancouver are not connected to the formal health care system, and are thus at elevated risk of adverse medical outcomes, including drug overdose (Kerr et al., 2005).

The 2008 Metro Vancouver Homeless Count found 1,372 people who were homeless in the City of Vancouver[1]. This number of homeless individuals represents a 23 percent increase since the previous count in 2005. Notably, between 2005 and 2008, the percentage of people who experienced homelessness for one year or more increased by 65 percent, representing 48 percent of people counted in 2008. In addition to the significant increase in the rate of

[1] The 2008 Metro Vancouver Homeless Count also identified an additional 1,037 homeless individuals in suburban

homelessness, self-reported rates of mental illness and addictions have also increased significantly, by 86 percent and 63 percent, respectively. A 2007 Provincial estimate of the population of adults with severe mental disorders (including substance use disorders) estimated that 1,800 adults in Vancouver are absolutely homeless and an additional 2,280 adults are at-risk for homelessness (Somers, 2008). These reports suggest not only a significant increase in the rates and severity of homelessness in Vancouver, but that a substantial number of people are affected.

The Downtown East Side (DTES) community, home to approximately 16,000 individuals, is unique to the Vancouver context. Many individuals in the DTES are homeless or live in unstable housing conditions, resulting in high rates of health and social service needs. Vancouver Coastal Health (n.d.a) estimated that 3,200 individuals in the DTES have significant health problems and an additional 2,100 have more substantive disturbances that require intensive support and services. Other estimates suggest an even greater level of need. For example, Eby and Misura (2006) estimated that 5,000 injection drug users in the DTES are infected with Hepatitis C or HIV/AIDS. Unfortunately, many individuals do not receive treatment for their conditions other than medical care through Emergency Departments (Kerr et al, 2005).

Although estimates of the clinical, social and housing service needs within the population of people who are homeless with mental disorders vary widely, it is clear that the variability and severity of need within the homeless population requires interventions that respond to individuals with both high and moderate levels of need. In response to the growing levels of homelessness in Vancouver and related issues in health and social problems, several non-profit organizations have established housing and other supportive services, many of which are located in the DTES. However, while Provincial ACT Standards have been developed and a Provincial Advisory Committee has been established to initiate ACT province-wide, there is currently only one ACT team in Vancouver (initiated within the past year), and only three province-wide. Thus, a critical element of context in Vancouver is the lack of basic service components (i.e., Housing First, ACT, ICM). This dearth of services may help explain the magnitude of complexity and tension in planning and implementing the At Home Project (i.e., not merely bringing people together around a common framework, but introducing key components of the framework at the same time).

The high concentration of Single Room Occupancy (SRO) hotels is also unique to downtown Vancouver. A high demand for low-income housing is evidenced by the 0.5 percent vacancy rate for bachelor suites in Vancouver. As a result, affordable housing is far beyond the shelter allowance of people receiving income assistance. The average rent for a bachelor apartment is $736 per month, almost double the $375 monthly shelter allowance. In general, housing in Vancouver for people with multiple barriers due to substance use and other mental disorders has been in *congregate* settings, and this trend is continuing with the purchase and renovation of a number of SROs and the development of congregate housing on 12 city sites.

Growing civic commitment and public concern in Vancouver has been directed toward

improving the health, autonomy, and quality of life among those who are homeless and have mental disorders. In November 2008, Vancouver's Mayor struck a Task Force to address the issue of homelessness. Numerous city- and province-led initiatives have recently addressed challenges related to homelessness, including reforms to the justice system (e.g., Community Court), expanded mental health services (e.g., Burnaby Centre for Mental Health & Addiction), access to income assistance (e.g., Homeless Outreach Teams), and investments to stabilize housing stock (e.g., purchase of SROs and development of additional supportive housing). If these activities and commitments fulfill their promise, they will significantly improve the standard of "usual care" for homeless people with mental disorders in Vancouver.

In summary, the *At Home Project* addresses a critical gap in the research evidence surrounding housing and services for a growing population of vulnerable individuals. While service agencies and institutions have struggled to overcome differences of organizational cultures, mandates and styles of work, the *At Home Project* has encouraged diverse stakeholder groups to come together and establish a common framework. The development of a philosophy of shared leadership among high-performance teams that can transcend organizational boundaries is vital for not only the success of the project, but for the country to gain the knowledge needed to provide effective housing, health, and social services to individuals in need.

Methodology

Qualitative methods were utilized in order to examine how the Vancouver At Home Study service provider teams implemented the housing and support interventions in the second year of the project. A semi-structured, qualitative interview guide for both individual interviews and focus groups was developed in consultation with the National Qualitative Working Group. Consultation with the National Qualitative Working Group assured that the interview guide was generally consistent across all study sites and that it adequately addressed key implementation issues raised in the first year.

Interviews with stakeholders were conducted during January and February 2012. The Site Coordinator and the Team Leaders for the housing procurement and three intervention teams were contacted by e-mail in order to schedule an interview or focus group. Three landlords were contacted by telephone. All interviews and focus groups occurred face-to-face, except for the interviews with landlords (n=2) which were conducted over the telephone. See Table 1 for a summary of individual interviews and focus groups by gender.

Table 1. Number of individual interview and focus group participants by gender

	Total	Gender	
		Males	Females
Individual	**5**	1	4
Site Coordinator	1	-	1
Service Provider	2	1	1
Landlords	2	-	2
Focus Groups	**3**	**6**	**12**
ICM	8	1	7
ACT	7	3	4
CONGREGATE	3	2	1

The final sample consisted of 23 individuals (five individual interviews and three focus groups), all of whom were involved to some degree in the implementation of the project during the 2011 calendar year. Twenty individuals identified as service providers, one individual was the Site Coordinator, and two individuals were landlords/building managers. A few staff members from the ACT and Congregate teams were unable to attend the focus group sessions due to staffing rotations and prior commitments.

A university researcher, who is also the Research Coordinator for the project, conducted, recorded, and transcribed the interviews and reviewed and coded the transcripts. One other research assistant independently reviewed the transcripts and identified key themes. In order to reach consensus surrounding the key themes, the two coders held two meetings to review each other's coding and to discuss interpretations and recurrent themes. Once consensus was reached, a summary document of findings by question was prepared. Notes from the observation of the Fidelity Assessment feedback sessions held with each service team as well as the Fidelity Assessment Report provided to each team were also used as context for the interviews and focus groups.

Findings

Year Two Fidelity Assessments: Overview

Overall, respondents from all teams reported that the fidelity assessments (FA), conducted on December 6th and 7th, 2011, accurately reflected their strengths and weaknesses, and no significant discrepancies were noted. In addition, all respondents reported that the second FA was proactive and constructive in highlighting areas for further attention and service development. Compared to the first round of FA, teams found the process of the second FA to be more collaborative and the feedback to be more focused and useful.

The **ACT team** was recognized for their exceptional level of internal communications, philosophy of care, and commitment to social justice. In particular, the FA team highlighted the effectiveness of the team's morning meetings, level of assertive engagement, commitment to creating choice for clients, and the number and variation of goals developed with clients. Technical assistance included suggestions around expanding their supported employment practice and addressing isolation and loneliness among participants.

The **ICM team** was recognized for their resilience and strong team culture despite significant staff turnover in the past year. In addition, the FA team noted that the ICM team has created strong partnerships in the community and have employed creative harm reduction and motivational interviewing techniques. While the FA team noted that the ICM team has identified a broad range of goals with participants, they would like to see clearer documentation of the team's work in case notes. Technical assistance included ways to increase employment, specific case conferencing, and how to develop the team's peer support services.

The **Bosman (congregate) team** was recognized for their commitment to social justice and therapeutic care without imposing their values on residents. The FA team noted that the Bosman staff have done an excellent job of navigating the challenges of a blended role of housing provider and case management team. The Bosman houses participants at all stages of change and recovery and staff regularly engage in motivational interviewing, harm reduction, and conflict transformation practices. Technical assistance focused on educating the FA team about the Bosman approach, particularly conflict resolution and restorative justice practices.

Improvements

The FA team and the all stakeholders interviewed noted a number of improvements in how services are implemented that have developed over the course of the past year. The end of participant recruitment, along with time and experience, have allowed teams to develop more coherence and maturity which is reflected in both participant outcomes and in the quality and diversity of external partnerships.

Team Maturity

The FA team, and all stakeholders interviewed, observed a shift in tone among the intervention teams from initial chaos, to semi-crisis, to stable teams that work effectively together and communicate an increasing confidence and maturity in all aspects of their operations. It was frequently noted that the end of participant recruitment allowed teams to pause and assess who was on their caseload, available resources, and to focus on working with participants around goals rather than on the time-consuming work of assessing and housing new participants. For example, according to one respondent:

"There's considerable stress associated with not knowing who you're going to get or when. Teams now know what they need to have in place to be effective and are putting that in place."

It was also noted that teams have a deeper recognition and acceptance of their limitations and are building deeper competency in their areas of strength. In addition, teams have been more intentional around soliciting feedback about their services from participants and being creative to address gaps.

Another general shift noted by many stakeholders has been from broad, oversight meetings to focused meetings that address on-the-ground issues. For example, a number of respondents noted that weekly meetings of the intervention and housing teams have allowed space for communication and problem-solving around key housing and re-housing issues. These meetings evolved over time in response to a need for specific problem-solving around challenging participants and housing situations.

Partnerships

Another key improvement noted by the FA team was the development of key partnerships with community agencies and raising awareness and receptivity of Housing First and multi-disciplinary service teams in key systems. For example, according to one respondent:

"It's no longer a question of whether scattered-site is needed or that a non-profit can be effective delivery services."

All teams have found it easier to navigate and negotiate the broader system of care over the past year. A more collaborative relationship has developed with many key agencies, due to processes that allow people from different agencies to get to know each other and share information. This has resulted in increased trust where partners "do what they said they'd do" and a willingness to accommodate and problem-solve from both sides. For example, staff from the Bosman participate in a Neighbourhood Advisory Committee that meets quarterly. According the Bosman staff, neighbourhood complaints have reduced significantly as well as the *NIMBY* (not in my backyard) attitude from local businesses and stratas that was palpable at the beginning of the project. Similarly, staff from ACT, ICM and the Housing Team meet regularly with BC Housing and have developed an effective partnership.

All teams have had practicum students from various disciplines join their team for a period of time. This has exposed students in diverse fields (e.g., nursing, family practice, psychiatry, social work, addictions counseling) to a unique model of community-based care and has helped to created bridges with the community.

Participants' Well-being

All teams reported that they have witnessed remarkable changes among many participants over the course of the past year. While there is a group of participants within each team that

has not engaged in the project and/or whose health has deteriorated, the majority have engaged with the teams, have remained stably housed, and are working towards identified goals (e.g., family reunification, reducing substance use, managing money, etc.). All teams noted marked reduction in criminal justice involvement and probation, and several participants have significantly reduced their substance use. In addition, some participants who entered the project with untreated psychosis have stabilized remarkably well and have engaged with the teams around medication compliance.

Housing Procurement

Despite low-vacancy rates and the inherent challenges in finding affordable rental units in the Vancouver housing market, the housing team was very successful at engaging a range of landlords and property management companies. The housing team obtained a wide variety of good quality housing units in 22 different neighbourhoods. Only one property management company has left the project and three participants continue to live in their building. A few smaller landlords have left the project due to challenges with individual participants.

The housing team attributed their success, in part, to the level of support that they are able to provide to landlords. The housing procurement lead is very clear with landlords regarding expectations and the level of support available through the project. He responds promptly to landlords' needs, helps them trouble-shoot issues with particular tenants, and generally liaises between the tenants' support teams and the landlords. The housing team's ability to offer prompt and concrete help to landlords has allowed the development of trust and a good reputation for the project in the community. Being able to offer to pay for damages was seen as particularly important for gaining trust and building relationships with landlords. According to the housing team, provision of tenant insurance helped sell the project to landlords at the beginning but is not necessary. Guaranteed rent is a strong incentive for many landlords, especially smaller firms which cannot afford vacancies in their units.

"Compared to other landlords, those in our project get a great deal of support … We underestimated how important that support is. It's like an extra set of hands helping them do their job."

A flexible rent cap allows the housing team to access a range of units from $750 to $1,350 in monthly rent; this is preferential to a static rent cap, which would likely restrict access to poor neighbourhoods and poor quality buildings. Also, static rent caps often result in tenants using their support allowance, which impacts quality of life and ultimately residential stability.

Another key factor in the success of the housing team was the strong relationships and trust that the housing team developed with the service teams, resulting in an integrated and collaborative approach. Finally, the housing team was situated in a mental health organization and was staffed by people who have extensive backgrounds in mental health and homelessness, as well as strong business skills.

Compared to the recruitment phase of the project, the housing portfolio is now more limited. The focus of housing procurement has shifted from broad searches (quantity) to more specific housing searches that match individual participants' needs (quality). Several units that were not working well for various reasons have now been dropped, which represents a shift from "taking whatever we could get to being more selective." The housing team noted that, in future, they would like to engage larger property management companies, perhaps as project sponsors, as well as the private condominium market.

Continuing and Emerging Strengths

Key strengths include the development of partnerships with a wide variety of external agencies and collaborative, shared models of working together; and healthy team cultures that allow space for creativity, reflection, and innovations.

Partnerships

All respondents noted that the intervention teams have a stronger sense of how they fit into the broader system of services. All teams noted that, at first, they felt somewhat isolated from the broader system but have now built deeper relationships with other organizations and are successfully navigating and negotiating the health care, social service, and criminal justice systems. This change was attributed largely to time and the development of collaborative relationships on the part of the staff and leadership teams. For example, a monthly breakfast meeting allows for regular communication and problem-solving between the intervention teams and staff from BC Housing. Through being responsive to BC Housing's concerns, the At Home project has cultivated a sense of shared achievement and trust. The teams have respected constraints that BC Housing has established in certain buildings (e.g., tenant mix, age) and related decisions around client fit. Also, some participants from the ACT team gave a presentation about the Housing First ACT model to BC Housing managers, which helped the model "come to life" for this organization. The service teams continue to be client-centred but have also learned to be flexible and appreciate the perspectives and constraints of landlords and other organizations. According to one respondent:

"I think the project has done a lot to foster collaboration within the sector rather than an Us versus Them attitude."

The development of strong partnerships with other organizations has allowed for the development of progressive and innovative practices. For example, the ACT team noted that, in addition to maintaining a strong recovery and clinical orientation to their work, they have incorporated unique approaches such as narrative therapy and aboriginal spiritual practices. One of the ICM case managers visits a French-speaking participant along with a worker from a francophone organization who has a longstanding relationship with the client. Similarly, the Bosman staff have developed key relationships with a wide range of organizations including lawyers who understand mental health and addiction issues, staff in the local emergency

department, and medical specialists. Working with other organizations and initiating case conferences across disciplines has helped to foster a collaborative approach which improves care for participants and provides support for staff.

"We had to work hard to build these relationships but now they have opened up creative opportunities around how to really work with people rather than slotting them into a program."

Team Culture

All teams noted a healthy team and work culture that is reflective, tolerant, and maintains deep respect for individual clients regardless of their history or behaviour in the project. This culture allows teams to be nimble and flexible in their work, and to balance more authoritarian versus more lenient approaches. All teams noted that working with At Home participants is very challenging and that adequate staff resources are critical to a well-functioning team. For example, the ICM team moved from using designated primary workers to a shared model, which reduces the burden on individual case managers who were carrying a caseload of 16 to 20 clients. All ICM participants are reviewed in a weekly meeting so that all case managers are aware of the issues and can provide suggestions, support, and a consistent approach to care.

While both the ACT and ICM teams have experienced considerable staff turnover, the Bosman has had a stable staff complement over the course of the project, other than several maternity leaves. Staff from the Bosman credited the team's stability to a very supportive management, effective team meetings, and an interdisciplinary approach to the work. According to respondents from the Bosman:

"Staff are very curious and the environment in the building and in [the parent organization] allows for integrated care and sharing of ideas, skills and even jobs. We've taken interdisciplinary to a new level. No one has huge egos here. We're humble and curious."

"I've never worked in such a supportive and collaborative place. The team is so committed to what it does and I think it's reflected in our communication and in the changes we've seen in our clients."

Continuing and Emerging Challenges

Several challenges that have been ongoing since the beginning of the project include consistently engaging a small group of participants in housing and support services and maintaining stable staffing levels on the ACT and ICM teams. Emerging challenges have predictably included (re)-engaging participants in work and educational endeavours and a variety of housing and re-housing issues.

Housing Fit

For a small group of participants on all teams, there have been sustained delays in housing, usually related to personal challenges and/or preferences. Scattered-site market housing is not a good fit for everyone, especially participants with complex physical and mental health problems (e.g., older participants with incontinence and mobility issues; older adults with dementia who are smokers). In these cases, the required care load (i.e., daily or twice daily visits) is much greater than what the team can offer. Some participants are not able to live independently and yet the teams are only able to offer one model rather than a range of step-up/step-down options. In a few cases, the teams have tried to find alternative accommodation to meet individual needs such as small nursing homes or abstinence-based supportive housing. However, given that the project is viewed by other agencies as having access to many resources, it is often hard to secure alternative resources for project participants.

While teams have successfully engaged most participants, a small number are difficult to engage in any fashion, despite consistent and creative efforts. The ACT and ICM teams hold a weekly meeting with the housing team to discuss on-the-ground challenges and creative solutions. In addition, teams have consulted and worked creatively with other organizations that work with particular challenging clients. Some respondents noted that they might have identified this group of "non-engagers" more quickly, but also did not want to make too many assumptions as many participants that initially presented as challenging have engaged with the teams and remain stably housed. According to one respondent,

"We identified non-engagers in a more gradual way, and I think it's an open question around whether to move fast or more gradually on this."

Staffing Issues

Challenges around staff burnout have notably decreased since participant recruitment was completed in June 2011. Nevertheless, as noted above, there has been substantial staff turnover on both the ACT and ICM teams, although senior team leadership has remained stable. Staff are very committed to the Housing First model and changing the broader system for people who are marginalized. While staff are ethical and hard-working, they often work through breaks and lunches which makes it difficult, at times, to sustain energy and motivation. The ACT team noted that finding staff coverage is challenging because most casuals do not have experience with the model; as a result, it is not uncommon for the team to be short-staffed, which creates particular strain during crises. Similarly, the staff budgets do not allow for "back-fill" of staff; bringing a new person into an outreach team is a challenge given that they do not know the clients and new members need to work in pairs for a considerable period of time.

In addition, many participants in scattered-site housing do not have phones, which makes it challenging for outreach staff to contact people and creates considerable excess work that does not result in client contact. Another standing challenge is around "cheque day," the third Wednesday of each month when income assistance cheques are issued. Given that cheques

are issued on the same day for everyone, it is challenging to help everyone budget around that day and manage the chaos involved. Nevertheless, all teams noted that the stress and staff burden associated with cheque day has subsided over the past six months.

Vocational & Educational Goals

The FA team encouraged the ACT and ICM teams to engage in more conversations with participants around work and education. Given participants' stages of recovery, the ACT team also had also identified this as a focus for the team. According to the ACT team, it is challenging to find the time to develop a systematic approach to vocational support. While the team is doing work in this domain with individual participants, the vocational specialist is trying to meet with potential employers and create a pool of resources in order to respond to participants' needs. Despite having a dedicated vocational specialist on the team, "the urgent often overtakes the important;" when there are crises, all staff are needed to respond, and more distal goals tend to be postponed.

Given the congregate living arrangement at the Bosman, staff have been able to create a number of work and volunteer opportunities for participants including meal preparation, street gum removal, assisting with laundry, taking care of plants, and so forth. However, engaging participants in meaningful activities including work and volunteer opportunities in the broader community continues to be challenging.

Housing Procurement

In the first FA, the housing team was encouraged to look for units in areas outside of the city. In response, the team procured units in Burnaby and on the North Shore but received pushback from the service teams who had difficulty servicing these areas, especially after hours. To the greatest extent possible, the housing team tries to honour a participant's choice of neighbourhood. This tends to be easier for ICM participants because the team brokers services rather than provides them directly. It has also been suggested that the housing team obtain more housing in the Downtown East Side (DTES); however, very little good quality and affordable housing is available in this area (rental units are very expensive; co-op buildings and social/supported housing units are full). The housing and intervention teams agreed that about 10% of participants would choose to live in the DTES if good quality housing was available.

In addition to challenges posed by the low vacancy rate in the Vancouver rental market, many units are non-smoking (additionally, smoking is increasingly prohibited on balconies). Given that most participants desire units that allow smoking, the available stock is further limited. Several participants request units that allow pets, which restricts choice; however, pet owners tend to be quite flexible regarding where they want to live.

Housing and Re-housing Issues

A number of implementation issues were identified in relation to evictions, planned moves, and choice moves as well as participant choice and housing fit.

Evictions, Planned Moves & Choice Moves

All respondents voiced a strong commitment to re-housing participants, which is based on the assumption that safe and secure housing is a human right and necessary for recovery from mental illness, trauma, and substance use. However, all respondents recognized that housing is not a panacea and that it is important to normalize challenges for participants, including evictions, so they are not interpreted as failures. According to the housing team, moves tend to fall into three categories: (1) evictions or forced moves; (2) planned moves that attempt to prevent eviction and address issues that are arising in the participant's current housing situation; and (3) choice moves that are initiated by the participant. According to respondents, for the most part, all three types of moves have been collaborative and successful. Many participants allowed friends from the street to live with them or otherwise disturbed neighbours in their first apartments. With help from the teams, many of these participants have learned how to manage guests and other situations, whether it be through problem-solving strategies or changes to lifestyle, neighbourhood, and/or medications. In the case of evictions (and other types of moves), the teams reported that they engage in non-judgmental conversations with participants around "what will be different" as well as the financial consequences of moving. Notably, the ACT team has developed a non-punitive way of responding to evictions through writing letters to participants which focus on natural consequences and joint commitment around what will look different next time. Teams have also developed groups to provide participants with the space to talk to each other about strategies to maintain housing. As a result, evictions and planned moves have dropped significantly over the course of the project (i.e., 30% of ACT and ICM participants are living in their second unit; 10% in their third unit; and only 1% in their fourth or greater).

If participants are evicted multiple times, their choice of housing options diminishes. Both staff and participants have learned how to thoughtfully navigate these natural consequences. This has been a learning experience for many team members as the principle is seemingly in conflict with the key principle of choice inherent to Housing First. The ICM team noted that having access to transitional suites has been very useful as they allow participants to reflect on their last residence and prepare for their next move. The ACT and ICM teams reported that respite care is very difficult to access, as existing services tend to have very low tolerance for difficult behaviours; therefore, teams have had to use homeless shelters in place of respite care.

A primary, albeit rare, challenge is when a participant refuses to leave a building after eviction. Oftentimes, this involves participants who have not engaged with service teams for various reasons. Even though the project continues to pay the participant's rent, it is expensive and stressful for the landlord. Respondents stated that "the best prevention is early intervention" and noted that if a landlord complains about a participant the team responds immediately.

No participants have been evicted from the Bosman, however, 14 participants have moved out for various reasons including moving into abstinent-based housing, women's housing, or more independent housing; and moving out of town. Several participants have "no-go orders" for the Bosman and, thus, live elsewhere. The majority of these participants continue to receive case management and medication support from the Bosman team on an outreach basis.

Choice and Housing Fit

All respondents noted that the teams are committed to giving participants real choices, not just when they move into their first apartment, but even after they are housed. The ACT and ICM teams noted that choice of housing stock has diminished over the past year, particularly in more affluent neighbourhoods (e.g., Kitsilano, West End). It was also noted that most participants tend to take the first apartment they see, even if the neighbourhood, access to amenities, and/or building environment are not a good match. Teams are now trying to help participants clarify their needs and preferences in order to find a good housing match. Working together, the housing and intervention teams have been able to find some creative options for particular individuals. For example, laneway housing was secured for a participant who makes noise during the night (disrupting his neighbours). The owners have sold their home but have agreed to ask the new owners to keep the tenant in his suite. Further examples include finding concrete buildings and carpeted floors for people who pace, ground floor units for people who are in wheel chairs or have difficulty with stairs and elevators, and upper-level units for people with safety concerns. Efforts to accommodate family members, romantic partners, and roommates have also been made by the housing and intervention teams.

Given their experience with the At Home project, many participants who have been stably housed now have their own references and can look for their own housing. As stated by one respondent, *"For me, that is a defining moment of real independence. To see that someone can fill out his own credit check and references. They don't need us as much anymore."*

Although most participants view their apartment as "home" and make choices to maintain it, a substantially minority have not invested in their residence. Respondents suggested that this lack of investment may be due to a range of reasons including the time-limited nature of the project and the fact that the project pays the damage deposit.

Facilitators and Barriers to Housing and Recovery

A range of factors that can either facilitate or serve as a barrier to stable housing and recovery were identified. Key themes included characteristics of the parent service organization; participant experiences of isolation and loneliness; involvement in the criminal justice system; family reunification; and substance use.

Parent Organizations

The three service teams as well as the housing procurement team are all situated within non-profit agencies that serve homeless people in Vancouver. Several respondents emphasized the importance of the service organizations' openness to "doing things differently." According to respondents, all four teams are part of organizations that support "pushing the envelope" in a way that creates space to work creatively with minimal hierarchy or bureaucracy. Developing the At Home service teams was a risk for all organizations involved because there was no precedent for these models in Vancouver. All teams have developed their own blend of skill sets and competencies, philosophy and attitudes, and organizational culture.

Participant Isolation & Loneliness

All respondents noted that isolation and loneliness is a significant barrier to recovery for many participants, particularly those in scattered-site housing. The ACT and ICM teams have initiated weekly groups which have been somewhat successful at helping people find and develop a sense of community in their new neighbourhoods and with fellow participants. Learning to deal with loneliness is a process and an ongoing challenge for many participants, especially for those in more affluent neighbourhoods. Teams have tried to connect people with libraries; community, aquatic, and education centers; and other neighbourhood resources with mixed results. Several participants who live in the same building or neighbourhood have connected and share meals together occasionally. Some participants go downtown to socialize and return to their homes in the evening. It was noted that many women want someone to live with and struggle with living alone. Many participants spend considerable time watching television. As summarized by one respondent:

"While living alone can be very lonely for some people, home can also open a space to invite others as well as to cope with feelings of loneliness."

Given the congregate setting of the Bosman, isolation is less of an acute issue, however, many residents continue to struggle with loneliness and a few self-isolate. In such a setting, these individuals can quickly be identified and gently encouraged to leave their rooms.

Involvement with the Justice System

All teams have strong working relationships the justice system including mental health workers in the jails, lawyers, and the Downtown Community Court. Given that there is often a significant time lapse between the laying of charges, occurrence of a trial, and incarceration, a participant could make substantial gains through the project only to be incarcerated. One ICM participant who had been stably housed for 18 months and re-connected with his family after many years of avoidance is now in jail for three years. Some judges have given participants a conditional sentence in order to allow them to take advantage of the At Home project. For participants who have been incarcerated for shorter periods of time, it has been very helpful for them to be able to re-connect with their At Home team rather than adjusting to a new team. Teams noted that while most participants' involvement with the justice system has

decreased over the course of involvement in the At Home project, there are a few participants who recidivate frequently and very soon after release.

Family Reunification

According to the service teams, re-connecting with family is a goal for many participants and is an inspiring part of the work for many team members. In most cases, this goal was initiated by participants once they felt a sense of pride in their home rather than feeling ashamed of living on the street or in a poor-quality building. Many participants have made trips to visit family and have reconnected with their children. According to respondents, these connections with family motivate many participants to work toward continued recovery and maintaining their housing. When there is ongoing strain between a participant and family members, the teams have been able to mediate and support reunification. All teams noted that they have connected with many participants' family members and have spent a lot of time listening, providing empathy and support, and educating families about a wide variety of issues related to homelessness. Several teams noted that the quality of life for family members has improved as they are relieved from worrying about the safety of their loved ones.

Substance Use

Teams noted that the majority of participants frequently use substances. The teams described participants across the spectrum of use from abstinence, occasional use, reduced use, relapse, and continued use. All teams take a harm reduction approach to substance use and stated that their non-judgmental approach and persistence "no matter what happens" has allowed a number of participants to make significant strides towards reduced substance use. For example:

"We try to be there to help clients think through and deal with the consequences [of substance use] but without being too worried or attached to an outcome. You have to use a light touch, stay positive about next steps, and not fret if it didn't work out."

All teams noted that now that participants are not facing stressors related to living on the street, it is easier for them to manage triggers for substance use. Teams noted that frequent use of stimulants, such as crack and crystal methamphetamine, tends to lead to more problematic behaviours and evictions; while opioids tend not to interfere as much with housing and recovery. According to the ICM team, participants who maintain stable housing despite frequent and heavy substance use usually have strong relationships with at least one service provider and/or with a community of users with whom they can identify.

Critical Ingredients

Given their experience with the ACT, ICM and congregate service models, respondents were able to identify a number of ingredients that are critical to successfully working with adults with mental illness who have had long histories of homelessness and social exclusion. These key ingredients include the Housing First philosophy (immediate provision of housing; client choice;

no discharge criteria; commitment to re-housing), hiring the right staff, and the development of a strong team culture.

Housing First Philosophy

All respondents commented that it is difficult to dissect their work and prioritize key ingredients; however, all agreed that philosophical underpinnings and team culture are probably the most important ingredients. For example, all respondents noted that a key ingredient to successful housing and recovery is providing people with choice. As noted above, providing choice includes taking the time to ensure a participant is invested in their unit rather than just taking the first place they see, as well as helping participants to identify their housing needs and matching those needs to available housing stock. It was also noted that the Housing First model that allows for moving people into housing quickly is critical for building trust with participants and initiating recovery. For example,

"If we had more elaborate housing applications or had to do our own searches, it would slow the process down and impede our ability to engage people."

Both housing and service teams emphasized the importance of being responsive and proactive to issues as they arise, whether it be the deterioration of a participant's mental health, tension with other service agencies, or landlords' concerns. All teams noted that, when provided a home that allows for safety, a sense of dignity, and support around various health and psychosocial issues, remarkable change and learning can occur. For example:

"When you're alongside people as they've moved from the streets into housing, when you stand by through that process of ups and downs, it creates a bond and a trust that you can't create in other ways. This is really different from other outreach work."

All teams try to meet clients where they are at and take into account the broader system context (e.g., family, friends and associates, neighbours and landlords, other agencies). The ability to engage in outreach was seen as critical by all respondents. The intimacy created by meeting people in their own homes was also seen as important to engaging participants and facilitating change.

Team Culture

All service teams emphasized the importance of hiring dedicated and passionate people who have a deep respect and curiosity about people. Several respondents noted that the qualities of the team culture are just as, if not more, important that the intervention model. Good team communication cannot be underestimated and requires multiple tools (e.g., databases, electronic medical records, telephone, texting and email, team notes). Strong communication skills and a positive team culture allows for fluidity, collaboration, continuity of care, and recovery planning. Another characteristic of the "right people" is the ability to work amidst chaos. Several respondents noted that chaos comes with a lack of bureaucracy and allows for

innovation and efficiency. However, it is a very different work environment than an institution that has defined protocols and policy manuals.

“It’s been amazing to have such a rich, interdisciplinary staff and to try out a new model of care. This is such a better model for primary care. I see 20 to 25 people a day compared to 10 to 15 at a Community Health Clinic. I have pretty much 100% follow-up which I never would have at other clinics.”

While opinions differ within and among teams, all respondents agreed that a strong focus clinical and medical needs is not primary. Rather, teams focus on helping participants identify and work toward their own needs, whether they be medical or a variety of other bio-psycho-social-spiritual needs. Similarly, all respondents noted the importance of the teams’ ability to work with participants regardless of the circumstances. For example, several participants have been incarcerated, “fired” the teams, left the province, or have otherwise disengaged, and are welcomed back into the project. There are no discharge criteria or expectations that a person achieve a particular outcome. Having the ability and time to demonstrate that the “door is always open” is important when working with people with long histories of marginalization. However, several respondents noted that, given the need for persistent engagement through a series of successes and mistakes, the project timeframe may not be long enough to fully realize the benefits of this approach.

Involvement of People with Lived Experience (PWLE)

Although involvement of PWLE was included as a key objective for the At Home/Chez Soi project, locally it was not perceived to be a high priority at a national level. For example, with regard to the involvement of peers on the service teams, there were no requirements regarding peer roles other than the recommended peer specialist on ACT teams. At the outset, clear expectations, leadership, and comparable funding should have been devoted to peer engagement on all service teams as well as the research team. Instead, there has been inconsistent engagement of peers, missed opportunities for engagement, and no explicit accountability. It has been challenging to involve peers in advisory capacities when the resources and accountability are not in place to meaningfully engage them in the project.

Despite these structural challenges to involving PWLE, there are examples of successful engagement on all teams. The ACT team has a peer specialist who is highly valued by the team. The team attributed their success in engaging a peer specialist to the non-profit culture of equality and lack of hierarchy. The Bosman has engaged participants in a variety of jobs including cleaning, meal preparation, and caring for plants, as well as in special projects such as fund raising and street gum removal. The Bosman also has two peer coordinators who work with the team one day per week and run a participant-led group. The ICM team has developed a Participant Advisory Group to elicit feedback from participants on a wide range of topics.

Teams have also collectively embraced a Speaker's Bureau which is comprised of participants and is intentionally non-therapeutic and peer-led. The Speaker's Bureau gives voice to participants' experiences and allows them to take control over how they and their community is talked about; for many, this is a critical piece of the recovery journey. Finally, the Peer Coordinator for the project in Vancouver has been instrumental in keeping the involvement of PWLE on the project agenda; she also initiated a conversation and designed a survey to examine what peer support means for this population.

Engagement of Landlords

Two landlords who have been involved in the project for over one year were interviewed by telephone. Both landlords reported having a very positive experience with the At Home project, although they described a number of problems. Both landlords noted the importance of matching tenants to the building culture. For example, one landlord stated that in larger buildings (over 100 units), she prefers mature tenants over the age of 35 who are quiet. Both landlords noted that young people who engage in frequent noise making (e.g., holding parties, playing loud music, etc.) are the most challenging tenants, especially in buildings with more mature tenants.

Both landlords agreed that they treat At Home participants differently compared to other tenants. At Home tenants take longer to adjust to the building than typical tenants and may need frequent reminders around how to locate and operate amenities and live with other people. However, a key moment for both landlords was recognizing that two people in the program can be very different, which helped them see homeless people as individuals, just like everyone else: *"Sometimes you get good tenants, and sometimes you don't."*

According to landlords, problems are rare but tend to centre around not being respectful to the building or to neighbours and "not being finished with their previous life." They cited examples such as bringing street friends into the building and allowing them to sleep in their rooms or in hallways, partying, and dealing drugs from their apartment. Even when they have had to issue eviction notices, both landlords noted that tenants have been respectful: "*Everyone has been respectful and has made an effort. I can see that, but there is a line I need to enforce."*

Lessons Learned and Reflections

With the benefit of hindsight, respondents identified a number of lessons learned:

- ***Establish problem-solving groups earlier.*** At a broader level, it was noted that opportunities for small groups to meet and problem-solve around specific issues could have been created sooner, rather than relying on higher-level meetings that focus on general operations. It was also recommended that consumer and family non-profit organizations could have been engaged in the project much earlier. Finally, it was noted that more opportunities could have been created for research and service teams to collaborate and work together and share learnings.

- ***Rate of recruitment***. For the teams that relied on scattered-site housing (ACT and ICM), the rate of participant recruitment created considerable operational strain and affected the quality of care available to participants. For example, participants could not be housed as quickly, and the staff load required to assess and house a new participant meant that housed participants could not receive as much attention. Once a stable case load was established, teams were able to assess participant needs and balance crises and stability more effectively.

- ***Start relationship building earlier***. All teams noted that many relationships and clarifying of expectations with external partners such as Mental Health Teams, BC Housing, hospital inpatient units, justice programs, landlords and building managers could have started earlier. Similarly, several respondents noted that staff training and education could have focused on more practical issues such as how to deal with pests, hoarding, charting systems, and the Residential Tenancy Act. All teams noted that formal training for new staff, rather than a learn-as-you-go model, would be more effective.

- ***The Bosman*** staff stated that, with hindsight, they would designate half a floor for women only with FOB entry; and alcohol and drug-free floor; and perhaps a floor for individuals with significant cognitive impairment or other factors that make them particularly vulnerable to others. Given that participants were assigned to teams with very little collateral information, it took time for teams to learn about their participants' needs. The Bosman team also noted several limitations inherent in the building structure and design. For example, a purpose-built, concrete building would be much easier to maintain than an older building with carpet.

  Finally, the Bosman staff noted a number of lessons learned with regard to clinical services: complementary nursing shifts have been more effective than overlapping shifts; an autoclave for sterilizing would allow for more on-site procedures; and having access to electronic medical records and an on-site pharmacy from the beginning would have been very helpful.

- ***The Housing Team*** noted that providing a full month's damage deposit has not been as effective as anticipated, and that offering to cover repairs has been more important. Similarly, provision of tenant insurance (originally intended to be property liability insurance) was seen as unnecessary, although it was a good selling feature for landlords at the beginning of the project. Finally, the Housing Team noted that they would stagger intake into some buildings rather than moving several people in to one building at the same time.

Reflections on Self-care

Now that teams are more stable and are not dealing with as many crises as in the first year of implemention, they are starting to think more about self-care. The work is challenging and all teams have experienced issues related to burn out. As one respondent stated:

"Our clients are so diverse. You see severe mental illness, addiction, trauma, chronic physical conditions. You can't be an expert in everything. I'm constantly changing hats – counselor, educator, mom, advocate. I've grown and learned so much but it can be very tiring. It's good to pair up sometimes, even just to have someone witness what you've seen. Sometimes what we see is so dark and heavy and out-of-this-world. You have to debrief with someone because you can't take this work home to someone who doesn't know this world. It's so complex you can't explain it."

The work is particularly challenging for the ACT and ICM staff because individuals often work alone and don't always have access to the support of the larger team. Teams have experimented with different scheduling strategies as well as pairing up with colleagues. While pairing up is helpful, it puts strain on the number of participant who can be contacted each day. Both the ACT and ICM teams stated they have learned to "do more with less" and that the staffing models do not allow for good self-care.

Respondents noted that self-care develops slowly, with experience, and requires a great deal of self-reflection, checking one's boundaries and expectations of self and others. For example, according to one respondent:

"I have to ask myself, where am I operating from at this moment? Am I making this about me, my boss, or my client? If I'm feeling a lot of discord, when I dig deep, it's often because I've made the situation about something else, unconsciously. It's natural. But, if I'm able to recognize it and step out of it, I can gain perspective. I have to constantly re-evaluate and shift my own desired outcomes."

Looking Forward

Although all teams have achieved a sense of stability and coherence compared to the start-up phase, perhaps the biggest challenge lies ahead. As the project moves into its final year, maintaining cohesion and a continued sense of momentum and commitment will be a challenge across all teams. Sustainability is a concern for all teams and the uncertainty surrounding what happens to participants at the end of the project is already generating considerable anxiety. Staff have made BC Housing applications for all participants who are interested and are trying to transition more stably housed participants to community care agencies. However, there are few options available for many participants. Without the rental subsidy and case management support provided through the project, many participants will not be able to maintain their housing. Many participants have tried in the past to connect with

Mental Health Teams and community health clinics, but the office-based model has not worked well for them and difficult or challenging behaviours are often not tolerated.

All respondents expressed the hope that the scattered-site and congregate care models will be continued and included in a full housing continuum. Individuals with long histories of homelessness and social marginalization, as well as mental illness and complex health problems, have not been well served by the existing housing continuum. Options with more intensive supports, including interdisciplinary outreach models, are needed to ensure this population is stably housed.

"There's a real danger in giving people a home but no support services. Support services are critical.   You need to help link people up to the community."

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