An Evaluation of the Implementation of the Ottawa Supportive Housing for People with Problematic Substance Use Program

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Executive Summary

Background

The Ministry of Health and Long-Term Care of Ontario (MoHLTC) developed the Supportive Housing for People with Problematic Substance Use Program to provide rent supplements for permanent, subsidized housing and support services for people with problematic substance use who are homeless or at risk of homelessness.

In Ottawa, the program is delivered in partnership between the Canadian Mental Health Association (CMHA) - Ottawa branch and the Oasis program at Sandy Hill Community Health Centre. The program received funding for 96 clients. An evaluation study with both implementation and outcome components began in 2011. This document reports on the implementation evaluation conducted March 2013 to June 2013.

Method

The implementation evaluation was guided by four questions: 1) Was the program implemented as intended? 2) What factors supported the implementation of the program? 3) What factors hindered the implementation of the program? 4) What changes are suggested by stakeholders to improve the program?

Data collection involved interviews with key informants and focus groups with case managers and clients. Baseline client data gathered for the outcome evaluation are also included to determine whether the clients' characteristics are consistent with the intended client group.

Findings

Overall, the program was perceived by stakeholders as having been successfully implemented as a Housing First model intended to serve adults with problematic substance use. The critical ingredients envisioned by the key informants and case managers were in place, including ICM support and housing. Clients were generally receiving rent supplements, allowing them access to higher quality housing than they would otherwise be able to afford.

Comparing the intended program and the actual program, the program is serving the intended population of individuals who were homeless, or at risk of homelessness, and had problematic substance use. In addition to a high level of substance use, clients were reported to have compromised health including severe and persistent mental health problems.

At this time, the program is providing subsidized housing to most interested clients. All clients are receiving support from a case manager. Case managers have offered assistance with finding and maintaining housing, crisis counseling, and accessing other services. With involvement in this program, clients are able to access a range of other services, including health care and treatment for substance abuse (e.g., concurrent disorders groups and methadone maintenance treatment). Support for housing is also available through the housing coordinator. CMHA and SHCHC reported a good level of collaboration and efforts to work

together. The program had relationships with other agencies to support clients and to receive referrals for potential clients.

Despite this early implementation success, there is a realization by program stakeholders that there are finite resources dedicated to the program, creating uncertainty around the provision of subsidized housing. Other areas of challenge include the structure of the partnership between CMHA and Sandy Hill, developing landlord relationships, and clients' isolation.

Recommendations

1. Enhance vocational and recreational support by accessing specialist services or services in the community.
2. Develop peer involvement within the program, potentially as peer support or for program planning and development.
3. Clarify roles and responsibilities between organizations and between housing and support services.
4. Further engage landlords to strengthen the relationship between landlords and the program.
5. Clarify policy on vehicles as case managers were concerned about the financial cost of using their cars daily for work.
6. Clarify availability of rent supplements for future tenants since there is concern that rent supplements will not be available to all future clients.
7. Secure finding for phones for clients since many clients do not have phones, which creates challenges for staff trying to contact their clients and leaves clients with limited means to seek assistance in an emergency.

Introduction

In 2008, the Ontario provincial budget allocated $16 million over three years to fund a thousand units across the province for the Supportive Housing for People with Problematic Substance Use Program (2010 Annual Report of the Office of the Auditor General of Ontario). The Ministry of Health and Long-Term Care of Ontario (MoHLTC) intended this transfer-payment program to provide rent supplements for permanent, subsidized housing and support services for people with problematic substance use who are homeless or at risk of homelessness. The Canadian Mental Health Association (CMHA) Ottawa branch, and Sandy Hill Community Health Centre (SHCHC) in partnership, received funding in 2010 for 96 units.

This report describes the results of an evaluation of the implementation of the Ottawa Supportive Housing for People with Problematic Substance Abuse Program over a two-year period from its start-up in May, 2011 to June, 2013. The data for the evaluation were collected over a four-month period from March, 2013 to June, 2013. The report presents a qualitative description of the implementation of the program according to different stakeholders, including staff, managers, and clients.

Context

Site Description

The Supportive Housing for People with Problematic Substance Use Program has been delivered in partnership between Canadian Mental Health Association - Ottawa Branch (CMHA-Ottawa) and the Oasis program at the Sandy Hill Community Health Centre (SHCHC). The CMHA Ottawa delivers a range of services to the Ottawa community, including case management services and housing (e.g., owning housing units and administering rent supplements to house people with private and public landlords). CMHA was responsible for housing for the Supportive Housing for People with Problematic Substance Use Program, with the housing coordinator for the program administering the rent supplements.

SHCHC offers health and social services to individuals who reside or work in Sandy Hill and Ottawa East. The Oasis program at SHCHC provides health and social services to individuals who have, or are at risk of, acquiring HIV or Hepatitis C, and who also experience barriers such as using street drugs, mental illness, homelessness, or involvement in the sex trade. The services that are offered at Oasis include a drop-in centre, medical professionals, counseling, street health outreach, dietitian, needle exchange, and complementary care. The Oasis program at SHCHC delivered intensive case management (ICM) support for this program.

Description of Intended Program

The following sections present the *intended program* Ottawa Supportive Housing for People with Problematic Substance Abuse Program (henceforth referred to as "the program"). The term *intended program* refers to the program as it was initially conceived and specified by the

program designers. To understand the intended program, we relied on documentation from the Champlain Local Health Integration Network (LHIN) and the MoHLTC, such as the funding letter to CMHA and the Supportive Housing for People with Problematic Substance Use Guidelines (2010).

Goals and Objectives of the Program

According to the MoHLTC, the goal of the program is to "increase the health and social outcomes of people with problematic substance use who are frequent users of the addiction system (particularly withdrawal management services) by providing stable housing" (Supportive Housing for People with Problematic Substance Use Guidelines, 2010). The objectives of the program are to reduce the frequency of readmission to addiction programs, reduce involvement with the criminal justice system, increase successful tenancy, and reduce repeated use of emergency and acute care.

Program Funding

The MoHLTC budgeted $16 million over three years to fund a thousand rent supplements across the province for the Supportive Housing for People with Problematic Substance Use transfer-payment program. In Ottawa, the Supportive Housing for People with Problematic Substance Use Program received $1,008,000 in annualized funding beginning in July, 2010, to support 96 units. The intensive case management (ICM) services are funded by the Champlain LHIN.

Intended Client Group

The program was intended to serve people who are homeless or at risk of homelessness and have problematic substance use. Other characteristics of the intended client group included frequent use of the addiction system, having complex addiction problems, and potentially having a concurrent disorder. In addition, individuals who were recent users of an addiction treatment program and assessed as having a high likelihood of benefiting from supportive housing were to be given priority.

Services to be Provided

The funding letter and the program guidelines indicated that services were to be provided at a ratio of eight clients per staff member for case management. As described by the MoHLTC, use of the support services was to be voluntary and the services were to be individualized to meet the needs of clients. Housing was to be provided based on a Housing First model (Tsemberis, 2010). The support services should assist the client in maintaining their housing and provide connections to substance abuse treatment when desired by clients. Support was to involve coordination and integration of services, follow recovery and harm reduction philosophies, be responsive to "the relapsing nature" of problematic substance use, link to other community services, offer integrated, multi-disciplinary teams, and build on the addiction treatment system (e.g., work with withdrawal management system). The rent was to be geared to income. The housing was to be integrated into the community, and the housing was to provide a safe, secure environment.

Overview of the Evaluation and Evaluation Questions

The main objectives of the implementation evaluation were to: (1) provide useful information to support decisions regarding program improvement, and (2) inform the evaluation of program outcomes. The evaluation sought to answer the following evaluation questions:

1. Was the program implemented as intended?
2. What factors supported the implementation of the program?
3. What factors hindered the implementation of the program?
4. What changes are suggested by stakeholders to improve the program?

Evaluation Methods

Sample

The perspectives of a number of different groups of people were included this evaluation.

Key Informant Interviews

The program coordinator, housing coordinator, Oasis program director, SHCHC executive director, CMHA director of operations, CMHA housing program manager, and the executive director of Inner City Health all participated in key informant interviews. The interviews were completed in May and June, 2013. See Appendix A for the interview guide.

Focus Groups

In total, three focus groups were conducted. Two were conducted with nine case managers from the Oasis program and the third was conducted with eight program clients. Focus groups were conducted in March, 2013. See Appendices B and C for the focus group protocols.

Quantitative Data Collection

Program clients were also interviewed as part of an evaluation of the outcomes of this program. Clients were eligible to participate in the outcome evaluation if they were enrolled in the program by the end of October, 2012. Eighty-nine clients were initially interviewed, however, nine were removed from the study (death, $n = 2$; left program, $n = 6$; refusal to participate at follow up, $n = 1$). The baseline data from 89 clients will be included in this report to describe the program clients and to determine whether the clients' characteristics are consistent with the targeted population.

Procedure

Research team members conducted the focus groups with case managers and clients at the Oasis program site. The staff focus groups lasted approximately one hour, and the client focus group lasted 30 minutes. The majority of key informant interviews were 30 to 45 minutes in duration and were completed either in-person or over the telephone.

Interview and Focus Group Protocols

The key informant interview protocol included questions regarding the critical program ingredients, early and anticipated outcomes, contextual adaptations and local innovations to the program, partners, suggestions for improvement, and sustainability. The client focus group protocol addressed the services received, helpful components, unhelpful components, and suggestions for improvement. The case manager focus group included items regarding discrepancy between the intended and actual program, what is working well, what is not working well, relationships among partners, client involvement, structures and resources of the program, contextual issues, and program innovations.

Quantitative Client Interviews

Clients completed an interview with a member of the research team after their admission to the program. The interviews included outcomes measures to assess demographic information, housing history, physical and mental health, substance use, level of recovery, quality of life, and community integration.

Findings on substance use will be reported. Substance use was measured using the Drug Abuse Screening Tool (DAST-10; Cucco & Carey, 1998) and Alcohol Use Disorders Identification Test (AUDIT; Babor, Higgins-Biddle, Saunders, & Monteiro, 2001). The DAST-10 is a 10-item self-report measure intended to screen for problematic drug use. Response options are *yes* or *no* and total scores range from 0 to 10. The levels of drug use include: no problems reported (score of 0), low (score of 1 to 2), moderate (score of 3 to 5), substantial (score of 6 to 8), and severe (9 to 10). The AUDIT is a 10-item self-report measure to detect harmful or hazardous drinking. The items address alcohol intake, dependence, and the negative consequences of alcohol. Total scores range from 0 to 40. Scores over 8 are indicative of harmful or hazardous alcohol consumption.

Data Analysis

All focus groups and key informant interviews were audio recorded and transcribed. Research team members used a general inductive approach to code the data and to answer the research questions guiding the evaluation of implementation (Thomas, 2006).

Initial coding of two key informant interviews was conducted in a group by the three research team members involved in data analysis. Coded themes were discussed until consensus was achieved on the themes. Afterwards, research team members conducted thematic coding individually for their assigned research questions. Subsequently, another team member reviewed the coding of themes.

Findings

1.0 Was the program implemented as intended?

To understand whether the program was implemented as planned, first we will explore whether the program was delivered to the intended population. Then we will examine whether the intended service components were implemented as expected.

1.1 Is the Program Delivered to the Intended Population?

The Supportive Housing for People with Problematic Substance Use program was to be delivered to individuals who were homeless or at risk of homelessness, had problematic substance use, and were high users of the addiction system. In general, respondents reported that clients were homeless and had problematic substance use.

According to key informants and case managers, the program clients have histories of substance abuse and were residing in shelters or on the streets when they joined the program. These are clients who are marginalized and typically considered difficult to serve. The key informants agreed that the clients are individuals who are physically unwell, have mental health concerns, and are complex. The clients were described as having a high level of disability and barriers to positive health and well-being.

Although the Supportive Housing for People with Problematic Substance Use program was designed at the provincial level to serve clients who had connection with the addiction treatment system, it was perceived by a key informant that in Ottawa the program was designed to work with a somewhat different population – to serve individuals who had problematic substance use, but who were not necessarily in contact with the addictions services system. However, another key informant indicated that harm reduction services are addictions treatment services and it is inaccurate to consider clients as not accessing addictions treatment services.

One key informant reported that the referral sources were not from the addictions systems as originally anticipated by the MoHLTC, but rather other agencies such as drop-in programs, Inner City Health, and homeless shelters due to the decision to target a unique client group. This perceived difference is explained by this key informant:

> *…initially this program in some ways was seen as a response to the needs of the addictions system, traditional addiction system, to be able to offer supports to people who otherwise were homeless for example, and therefore couldn't participate in treatment programs or some day programs because their lives were too disorganized, so, I think, initially this was seen as a way of providing resources to that population. The Ottawa partnership, I think, did something a little different where in that, in the sense that it was targeting people who generally were, had serious addiction issues but were not showing up in the addiction system really. So folks with high mental health and high substance use issues and that is different from another parts of the province were in a sense the rehab programs might be referring people.*

Quantitative findings

Quantitative information about the demographic and clinical characteristics of clients was gathered during the baseline client interviews. These data are described below.

Demographics. Of the 89 clients interviewed, 45% were male and 55% were female. At baseline, the mean age of clients in the evaluation was 40.10 (SD = 9.48, range: 19 to 60). Clients tended to have unstable housing situations having lived in a mean of 3.78 different residences/settings in the two years prior to the baseline interview.

Sixty-seven percent of clients reported having been diagnosed with a mental health problem at some point in their lives. The most frequent diagnoses were depression (34%), generalized anxiety disorder (18%), post-traumatic stress disorder (18%), bipolar disorder (16%), and schizophrenia (14%). Other reported diagnoses included attention deficit/hyperactivity disorder / attention deficit disorder (8%), obsessive compulsive disorder (6%), panic disorder (3%), fetal alcohol syndrome (3%), an unspecified anxiety disorder (2%), schizoaffective disorder (2%), and other mental health disorders (10%). No clients reported a developmental or intellectual disability, or a personality disorder.

Substance use. Clients endorsed high levels of problematic substance use. Approximately half of the clients reported a level of alcohol use that was considered harmful or hazardous (51%). The mean score on the AUDIT was within the harmful or hazardous range (M = 13.69, SD = 13.47). Clients also reported difficulties with drug use. The mean score on a measure of problematic drug use was 5.37 (SD = 3.07), which falls between moderate and substantial problems associated with drug use. Over half of the clients reported substantial or severe drug related problems. Figure 1 outlines the percentage of clients within each level of problematic drug use.

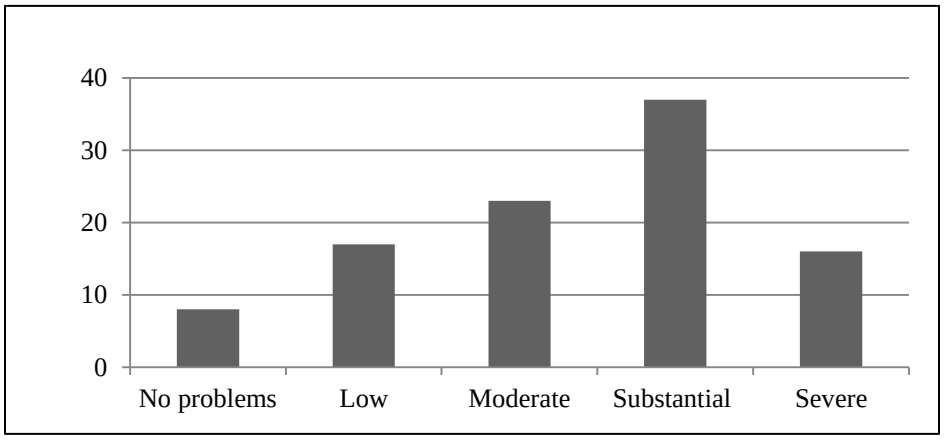

Figure 1 Percentage of clients with each level of problems associated with drug use

When both alcohol use and problematic drug use were explored together, 91% of clients reported moderate to severe problems with drug use and/or harmful alcohol consumption. Seven percent of clients reported a non-harmful level of alcohol use and a low level of problems associated with drug use. Two percent reported no problems with either alcohol or drug use. Given that, in some cases, the baseline interviews were conducted some months after admission to the program, there may be an under-estimation of problems associated

with substance or alcohol use. In addition, as we relied on self-reports, some clients may have underreported their problematic drug and alcohol use.

1.2 Are Program Components (Housing, Support, Program Values) Being Delivered as Planned?

Generally, case managers, key informants, and clients described a program that has been implemented as intended. Stakeholders agreed that current clients generally have access to subsidized housing as expected. All clients have a case manager. The program values have been reflected in the implemented program. An area in which the actual implementation differed from the intended implementation was adherence to elements of the Housing First approach such as not all housing units being scattered.

1.2.1 Housing

Clients had access to rent supplements ensuring that they paid no more than 30% of their income towards rent. This subsidized housing was perceived as key to the program's success by case managers and key informants. As one said, "*First and foremost is having access to rent supplements, having the money to provide people with affordable, you know, quality housing and I don't think people realize how much that helps*." Prior to the program, clients had trouble accessing good quality housing with the level of income support from Ontario Works or Ontario Disability Support Program (ODSP). The rent supplements allowed clients to obtain what was described by some key informants as independent, stable, safe, and good quality housing. Clients in the focus group agreed that their apartments were comfortable, private, and safe. However, case managers reported that there were concerns about security and pests in some buildings. Access to this stable housing through rent supplements was credited by key informants as helping clients to begin to stabilize and to focus on their health.

One area in which the actual implementation of housing was identified as differing from intended implementation was the scattering of the housing units. Initially, staff had attempted to have housing units scattered throughout the city. However, one rental company offered the program a significant number of units that were located close together within a few buildings, resulting in a number of clients housed in close proximity to one another. Though this enabled a number of clients to be housed in these units, it was noted that this housing has pest and gang issues.

1.2.2 Support

Support provided by the case managers was considered an important aspect of the program. One key informant said: "*…housing without case management is good. Housing with case management is excellent, right? 'Cause now it just creates a whole different set of supports."* The case managers reported providing a range of services including regular visits with clients, support with housing, counseling, crisis intervention, harm reduction strategies, support around leisure, advocacy, transportation, among other services. Clients noted that case managers were flexible in meeting them in a variety of locations, including their own apartments, Oasis, or other locations selected by clients. Some clients indicated that their case managers have visited them in jail. Clients noted that the frequency of visits depended on their

needs. They were visited more frequently when first admitted to the program, with a gradual decrease in the number of visits as they stabilized.

Other team members, including the housing coordinator, the program coordinator, and other case managers, were also involved in supporting clients. This was illustrated by one client's comment, "*I find it's not just my worker that's supportive. It's all the workers in this program. If I can't get ahold of my worker, there's a worker I can get ahold of and talk to.*" The high level of support provided by the program was viewed as important by key informants and was described as being determined by client needs. The overall level of support is eight clients per staff, including all program staff. However, the case managers carry a caseload of 12 clients as funds were used to create a housing coordinator position based on CMHA's experience and there is also a program coordinator.

1.2.3 Program values

Case managers and key informants agreed that the program has consistently adopted a Housing First approach in which access to housing is considered primary and substance use or mental health difficulties do not prevent clients from gaining access to housing, "*…that's always the message I've had here is Housing First regardless, right? Like people have rights, they're human beings, and I think we're still being sold that message*." In particular, two values were emphasized by evaluation participants: access to housing and choice.

Access to housing. Access to housing was identified as a central value of the program by key informants and case managers:

> *We're Housing First, I guess you could say, purists, or, yeah, purists. I believe and the program believes, that's one of our values, that housing is a right, not a privilege. We're not going to wait for someone to get better by any means. If they want housing and they're willing to look for it, we'll put them in housing.*

Clients are moved into housing as soon as possible with the assumption that they can successfully maintain housing. Client clinical characteristics, such as substance use or mental health concerns, do not impact on a client's eligibility for housing, and the program does not require clients to commit to treatment or to sobriety before accessing housing. Housing is perceived as a fundamental right regardless of whether clients use substances:

> *Sure, so for Housing First the idea is that you start with the assumption that everybody can live independently, and that people aren't require to kind of achieve anything or to maintain sobriety or to do something in order to earn housing. Housing is a fundamental right and so if you start by thinking that everybody has a right to housing.*

Client choice. Client choice and self-determination were described as important by key informants and case managers. This includes choice of housing, such as involvement in the process of selecting an apartment, and participation in programming. Clients indicated that the staff members of the program are helpful in ensuring that clients are comfortable in their housing. Clients reported that they did have the opportunity to select their housing. Said one client:

The apartment I'm in right now, the lease is almost up and it's not quite the fit that I want, so my worker and I are right now sittin' down and trying to figure out what type of apartment would better suit me and stuff, where I'd feel more comfortable in it. So she sits there and she asks me questions, like, what do you like and do you don't like?

A key informant spoke about the importance of client choice:

Another important concept of Housing First is responsibility, and clients making choices and that is absolutely critical in a Housing First model that the client have… are calling all of the shots, so they select the units that they want to apply for. They make all the choices around this. They make the choices whether they want to move out of the units or not, or whether they are satisfied with the situation, and that's really important because again remember they are coming from an institutionalized background and a lot of choices get made for them.

Clients also agreed that they have choice in what goals or priorities they would work on with their case manager:

Moderator: Who decides what to work on?
Client 3: Us.
Client 2: Us.
Client 3: We do. It's what, it's what, it's up to us.

2.0 What components supported the implementation of the program?

2.1 Staff

The characteristics of case managers were thought to be important in supporting the delivery of the program. These characteristics included being self-motivated, autonomous, and resourceful. Case managers viewed their colleagues as accepting and supportive, which was important to them. While the work itself is challenging, the case managers noted that the team has a lot of energy and works well together. Humour was important, as were patience and compassion. The hiring process was viewed as important to selecting case managers who would fit into the team and work well with the other case managers:

Being able to bring yourself to a professional level where you can work with your coworkers, understand your coworkers and brainstorm and problem solve, I think that that was a huge part of the recruiting process for this team and I think [the program coordinator] did a great job, along with the other members, to pick a team that would mould well together.

Case managers indicated that they rely on one another for support, or advice. Clients reported that their case managers were dependable, which was important to them. They also described their case managers as understanding and patient, even when clients are being difficult with them.

2.2 Programmatic Factors

There were various factors within the program that supported the implementation of the program, including the location of housing, support services, client feedback, supplies for clients, and resources for staff.

2.2.1 Location of Housing

The rent supplements were perceived by key informants as allowing for greater flexibility and choice with respect to where clients are able to live (i.e., clients can afford housing in a neighbourhood of their choice). The case managers and housing coordinator work with clients to identify neighbourhoods where clients would feel comfortable living and have access to important supports and resources. The clients agreed that the location of the housing was important. Moving out of the downtown was helpful for some clients as they felt that there was a lower chance of relapse if there was more limited access to recreational drugs in their new neighbourhoods. Clients reported that living in a new neighbourhood also limited their exposure to people who might lead them to relapse. Living away from particular neighbourhoods also increased the sense of security of certain clients, as they did not feel safe in their old neighbourhoods. Housing located away from downtown also deterred unwanted visitors, according to clients.

2.2.2 Support Services

Specific aspects of the support were perceived as contributing to the successful implementation of the program. These included the emotional support provided by staff, support with housing, transportation, and support in accessing services.

Emotional support. Clients reported that the emotional support provided by staff is important. The relationship between case managers and clients was characterized as being very positive. Clients emphasized feelings of closeness with the case managers, and described a sense of trust in the relationship. One client stated, *"My worker is my family."* Although support is only available during weekday working hours, clients described feeling connected to case managers and felt that emotional support is always there for them:

> *Client 3: It doesn't matter. Anything you have, anything you need, they're there for you.*
> *Client 2: My worker's the same way, too.*
> *Client 3: It doesn't matter, it doesn't matter. My worker, she's there for me 24/7.*
> *Client 2: Anytime, any day, weekends, week nights.*
> *Client 3: Yup.*
> *Client 2: Four o'clock in the morning. They're always there.*

Housing support. Clients often required support with housing, such as locating an apartment, applying to rent the unit, and then maintaining it. Case managers assisted clients in organizing and attending appointments to view apartments and complete paperwork. One client described not knowing how to rent an apartment after living on the street for several years:

> *I had no idea how to get an apartment. After living on the street for six years, not in the hotels that they got here, in the street exactly, six years. I didn't have no idea how to get*

an apartment no more. No idea, so he picked me around, he showed me the paperwork, he did a lot for me.

Because some clients may have limited skills for living independently in an apartment, case managers provide assistance to support clients in learning the skills required to maintain a household. The support is also available when clients struggle with keeping housing. Some clients found it helpful for case managers to serve as a go-between for them and their landlord.

Additional support with housing is provided by the housing coordinator who works with the case managers to find apartments, liaise with landlords, and address the paperwork for the rent supplement and obtain cheques for housing. Although the MoHLTC does not typically provide funding to administer rent supplements, CMHA decided to add the housing coordinator position, which is funded through the support budget. It was reported by a key informant that not having someone to administer the rent supplements would have likely caused strain within the program.

Transportation. Clients appreciated the transportation provided by staff members, whether it was to attend a regular group, or their appointments. Clients perceived case managers as open to providing transportation. One of the benefits of the transportation is that clients reported that their attendance at appointments has increased and, without that support, they were unsure whether they would attend as regularly.

Case manager support in accessing services. The ICM services were described as wraparound services where case managers are easily accessible to clients. Case managers were perceived as key in clients accessing services in the community, such as food banks and groceries. Case managers advocate for clients by helping them to navigate different systems, such as housing, ODSP, or legal systems. They also help coordinate services, linking clients to other professionals (e.g., health care). Clients noted that case managers attended appointments with them for support, or would attend meetings on their behalf. For example, one client who has trouble expressing himself described a case manager helping him to communicate with other professionals. Clients reported that staff are responsive to their needs and will find information for clients on programs and other relevant resources or services, *"Yeah, my worker will do all the research and will do everything for me. She goes out of her way and everything."*

2.2.3 Client Feedback

Client feedback had been sought in certain instances within the program in an ad hoc way. Case managers recalled consulting with clients when introducing new programming. A case manager described how clients residing in a specific housing site were encouraged to discuss building issues, *"We talked to folks about the gangs, and invited folks to come and speak about concerns, or problem solve what works, what doesn't."* The program also specifically sought feedback from clients on their relationship with their case manager, issues with their building, or safety of their units, and suggestions for improvement. Notably, the current implementation evaluation by external evaluators was pointed to by case managers and key informants as an example of how the program sought feedback.

2.2.4 Supplies for Clients

Clients have access to different supplies to support their move into their new apartment and to create a home environment. These have included different furnishings (e.g., bed, sheets, pillows, microwave, and air conditioning) as well as other supplies needed to maintain a home (e.g., mops, pots, pans, and toiletries). These supplies are intended to create a more comfortable environment for clients. Case managers and key informants indicated that clients have been quite positive about receiving these supplies:

> *I've had some incredible responses from clients when they realize and see for the first time, even though you know you tell them, it's the physical it's when they actually see it, can be quite overwhelming for them. Another big thing for the clients is the beds, that we get them the beds. And the fact that we even get them a double bed.*

Another key informant stated:

> *…we also had funding to get mops and pots and pans and, you know, toiletries and condiments and that sort of thing, so, you know, the more stuff you can make to… help them move into the apartment can make it feel more like a home. You can see that they don't have to leave as much, they don't feel like the apartment's so empty. So those are the key factors and ideally you'd have that all in place before the person moves in, or at least help them get all that…*

2.2.5 Resources for Staff

Staff had access to resources to support their work, including supervision with the program coordinator, a staff peer group, as well as opportunities for training.

Supervision. Case managers are provided with supervision and support in a variety of ways and reported that they are pleased with the supervision that they receive. They each have an individual, monthly meeting with the program coordinator to discuss clinical issues, such as updates on clients, clients' goals, what they have worked on, and boundaries. This regular clinical supervision was regarded as beneficial. Case managers also noted that they feel that the program coordinator provides them with autonomy and supports their decisions. The case management team also has weekly team meetings that provide tangible tools that can be used by case managers in their day-to-day work. Case managers indicated that they feel that support is always available from other case managers and the program coordinator.

The case managers also have a staff peer group during which they meet without the program coordinator present. This meeting allows case managers to share their knowledge and to discuss how to deal with different situations they experience. The staff peer group also provides case managers with an opportunity to connect and receive support about their work.

Training. Case managers have had access to different training opportunities to support their learning, including training in case management, concurrent disorders, and motivational interviewing. Case managers are encouraged to pursue training and there are financial resources available. This opportunity for training is appreciated, although it was noted that it was difficult to take time away from delivering services to clients in order to attend training.

Training that was relevant to the case managers was appreciated, such as training from a staff member who is involved with the concurrent disorders groups.

2.3 Organizational Factors

Organizationally, positive relationships within the ICM team and SHCHC support the delivery of the program. As the program is associated with SHCHC, clients can access a range of services that they could not otherwise use. The flexibility of the program was also perceived as helpful during implementation.

2.3.1 Relationships within SHCHC

Many case managers and key informants commented on the extremely positive relationships that existed within the case management team that allow the team to function well. The case managers were described as a tight-knit group, producing a true team environment. Case managers and key informants said that case managers collaborated well, were highly committed and engaged, communicated effectively despite limited in-person interaction, and were knowledgeable about each other's clients and caseloads. One case manager acknowledged being excited to come to work because of the good relationships with other case managers. Another case manager commented on the presence of humour in the relationship, which was regarded as bringing case managers together and helping them cope. A key informant described the case managers by saying:

> *Their ability to work together as a team is quite phenomenal… the synergy between the workers is absolutely astounding. The consensus around pretty much everything about the program is quite strong.*

Case managers described the nature of their relationships with other staff members at SHCHC in generally positive terms. Case managers also described the SHCHC staff as being approachable and helpful. Clients were considered to be welcome at SHCHC, with a positive environment for clients. Another case manager described how the existing agency had "absorbed" clients of the program, considering them to be SHCHC clients, too. Case managers felt that they had been incorporated into the centre; that SHCHC has been responsive to the program and that other services accommodate the program's clients. For example, clients who have been barred have been allowed to access services, such as seeing their physician, if their case manager accompanies them. This flexibility was viewed as important.

Case managers reported that SHCHC had a good reputation in the community. Consequently, other agencies are receptive to working with them and their clients.

2.3.2 Services at SHCHC

Several case managers and key informants acknowledged the importance of the resources -- including health care staff and counselors -- available to program clients through SHCHC as a whole. One case manager stated, *"Having different services run out of the same centre has been really beneficial, and like kind of a multi-care system and…So it's more than our team that cares for [clients]."* As the program is based out of Oasis at SHCHC, clients are able to use Oasis services, such as health care (e.g., physicians and nursing care), even if they do not fall within

the usual Oasis mandate (i.e., they are not at high risk for HIV or Hepatitis C). The case managers appreciated that they are able to easily seek advice from the healthcare providers on-site and then share information with clients. Clients also appreciated access to the healthcare services. There are also services for addictions, including methadone maintenance treatment, and clients can access mental health counseling. There are walk-in groups that offer a social and educational component. The clients noted that they have access to the drop-in. Some of the clients participate in a banking project in which they can set aside money for priorities later in the month.

2.3.3 Flexibility of the program

Case managers reported that the program was initially quite flexible. This allowed for it to develop into a unique, innovative program over time. A case manager stated, *"That's the one thing I really appreciate about it, that there was been opportunity to mould it."* Because of the relatively small size of the program, case managers are able to be flexible and try new things easily, for example, they tried a kitchen group, but attendance was low so they cancelled it. They appreciated the ability to adapt the program quickly.

2.4 Partnership Factors

Several partnerships facilitated the implementation of the program, including relationships between SHCHC and CMHA, and with Inner City Health and other community organizations.

2.4.1 Relationship between SHCHC and CMHA

Both case managers and key informants noted that CMHA and SHCHC had worked together in the past, and were familiar with each other's services, thus making them a "good fit" for partnering on the program. Oasis has a commitment to harm reduction and had worked with CMHA case managers. CMHA had experience with housing and ICM, so was able to provide guidance with program development based on their experience. For example, CMHA's experience and prior knowledge with housing and ICM prompted the creation of the housing coordinator position to administer the rent supplements. This position was described as contributing to the success of the rent supplement component of the program. CMHA was also able to use their experience to anticipate certain challenges that would be encountered as the program matured, which was also described as being helpful. One key informant stated, *"Their advice in terms of how they've been operating similar programs for a number of years, so I think that certainly was very helpful. We didn't have to figure this out from scratch and from nothing."*

The partnership was considered amicable, tight, highly integrated, and innovative. Case managers and key informants reported collaboration between the two agencies on almost every aspect of the program. The relationship between the two partners was described as featuring good will and mutual respect, which contributed to the success of the program. One key informant noted that the partners' had *"tremendous willingness to kind of adapt and adjust and work together, in a very cooperative and kind of easy-to-work-with model."*

Case managers described the housing coordinator as being very helpful, and they recognized the important contribution he made to the program. Key informants discussed the process of integrating the housing coordinator into the ICM team, which initially included having him

attend team meetings and spend time on-site at SHCHC for individual consultations with case managers as needed.

Despite a good relationship between CMHA and SHCHC, there were some challenges around the structure of the partnership that will be outlined in section 3.4.

2.4.2 Relationships between the program and other community service providers

The program had established partnerships with other community service providers who supported the program through referrals. Several case managers and key informants made note of the usefulness and effectiveness of the program's relationship with referral sources within the community who were able to identify appropriate clients to be considered for the program.

Case managers described the importance of nurturing relationships with community partner organizations. They recognized that some organizations were interested in more information about the program and more involvement in its activities. The case managers suggested that keeping these partners "in the loop" was important.

2.4.3 Relationship between Inner City Health and the program

When discussing community partners, many case managers and key informants referred to the relationship between Inner City Health and the Supportive Housing for People with Problematic Substance Use program. The two have clients who receive services from both agencies because Inner City Health refers clients to the program. Inner City Health and the ICM team collaborate closely to transition clients from Inner City Health into the program and to offer integrated care to the shared clients. The working relationship between Inner City Health and the program was described as beneficial to clients by a key informant: *"When the service providers are together, the clients always do better. When the service providers get it and it's a collaboration and, you know, it's always, always uniformly better for the client."* The close collaboration between the two agencies was described by a key informant:

> *You know, when there's a crisis with so-and-so, or so-and-so shows up in the shelter, and [Inner City Health] calls the worker, and so they know immediately that something's gone on and there's a whole support, care system that's very integrated between the two programs and that's why I say [Inner City Health and SHCHC] have a great deal of intimacy.*

2.4.4 Community health services

Linkages with other community health services and access to health resources outside of SHCHC have been important in addressing the needs of program clients. The program has access to consultations with specialists from the Department of Infectious Diseases at the Ottawa Hospital. The case managers are in contact with outside agencies used by clients, such as methadone clinics and community health centres. The Royal Ottawa Health Care Group is a newer partner that has offered mental health services to the program, including a psychiatrist and psychologist who visit SHCHC. Key informants indicated that these mental health professionals provide support in how to work with clients, understanding clients' capabilities,

and how to modify interventions to best meet the needs of clients. In addition to assessment of clients, the psychologist and psychiatrist are available for consultation with case managers.

2.4.5 Relationships between the program and landlords

Both case managers and key informants regarded the relationship between the program and landlords as being important to the success of the program. Landlords were considered to be key partners who needed to be recognized for their contributions to the program and to be supported whenever possible. As one case manager stated, landlords *"are taking a risk to have some of our folks around, and they have some legitimate concerns at times that we can support them with."* Another case manager emphasized the importance of fostering open communication with landlords, saying:

> *The communication involving the case managers, the client, the landlord, the mapping out the expectations of everybody involved….When there's an issue, you know, if there's a problem, the quicker we can discuss it and look into it, the quicker, you know, things can get resolved.*

3.0 What factors hindered the implementation of the program?

Several factors negatively impacted the implementation of the program. These included staffing, programmatic, organizational, partnership and contextual factors.

3.1 Staff

A staffing challenge that arose was SHCHC's bilingualism requirement for staff, which hindered the hiring process for case managers and reportedly slowed down the implementation of the program.

3.2 Programmatic Factors

Three programmatic issues hindered implementation. One challenge that arose during the implementation of the program was the difficulty that some clients encountered in moving into their own apartments. Some clients encountered problems with landlords when their case managers were in contact with their landlord. There were issues that affected client involvement in the program.

3.2.1 Transition to independent living

For clients who had been homeless for a long period of time, the transition into housing could be a difficult one. Clients were at times described by case managers as feeling isolated, overwhelmed, and unsafe in their housing. Some clients could only spend a few hours at a time in their apartment initially. One key informant also commented on the loneliness experienced by clients, saying, "*So, loneliness, the lack of meaningful social relationships that their drug-using friends were filling is a huge issue that people identify*."

Another key informant explained, "*Some clients, they move into an apartment, they go through a period of disorganization. They might even use more [substances] than they used to because now they have the space to use.*" Other suggested reasons for the initial increase in drug use included anxiety about living in a new space, new freedom, and access to friends. Case managers and key informants expressed optimism that these initial challenges could be overcome with time.

3.2.2 Case manager contact with landlords

Several clients stated that it was not always preferable for case managers to have contact with landlords and, that in some instances, clients would do best to directly interact with the landlords themselves. One client mentioned that as soon as his case manager began to communicate with his landlord, the landlord began constantly complaining about him to the case manager over trivial matters, leading to feelings of being heavily scrutinized.

3.2.3 Challenges with client involvement

A limited amount of client involvement in the program was described by clients, case managers, and key informants. However, a key informant reported that, "*It was on one of SHCHC's next goals for strategic planning is involving more peer group and peer involvement stuff as a centre-wide kind of thing.*" Some case managers and key informants questioned whether client involvement was necessary or advantageous for the program. Case managers were aware of other organizations in the community already offering client involvement opportunities that were being accessed by clients of the program (e.g., involvement as a peer support worker). Case managers also explained that client involvement would interfere with many clients' desire to distance themselves from members of their peer group, or from certain areas of the city as part of their recovery. One case manager described a number of clients who "*completely separate themselves, so they can be away from the lifestyle that they had when they first came into the program, as part of their recovery process.*"

3.3 Organizational Factors

Despite the support from other SHCHC staff, some case managers stated that there was a lack of familiarity with other staff in the broader agency given that the case managers work primarily outside of the SHCHC building. SHCHC staff did not always know or recognize case managers.

3.4 Partnership Factors

There were partnership factors that hindered the implementation of the program. These included challenges in the relationship between CMHA and SHCHC, divided funding sources, initial challenges in client transitions from Inner City Health to the program, and referrals.

3.4.1 Relationship between CMHA and SHCHC

Despite the collaborative relationship between CMHA and SHCHC, both case managers and key informants noted a number of challenges presented by the relationship between the two agencies. The relationship was described as being complicated, unclear, confusing, awkward and complex because of the funding arrangement. Case managers and key informants

reported being unsure about the roles and responsibilities of the two agencies, or about the lines of accountability within the program. One key informant explained the complex funding model that results in this confusion, *"It's a real complicated scenario. CMHA gets all the funding and then they give the case management part to SHCHC and they keep the rent supplement part. So, it makes for an interesting relationship."* The nature of the relationship, the reasons for it, and the consequences of it were all explained by a key informant who stated:

> *I think it adds a level of complexity that's not necessary for the program, and it creates a bit of a dual relationship between [SHCHC] and CMHA where [SHCHC] is a partner, but [CMHA] are also the funders. So it's a bit of an awkward situation to have set up this way. I mean we are amicable and things are…but I just find that it's a strange way of doing things…there was no real reason to set it up that way. So I'm not clear on why that was done, but I mean we had every intention of working in close partnership on the portfolio anyway. But I think that can create some issues for us. You know, say for example, if leadership changes in one or both organizations and you know decisions get made that would be different from decisions that would made by the leadership today, and some of the money gets clawed back for example, there's huge impact potentially on this relationship.*

Another key informant identified issues around confidentiality and record-sharing between the two agencies, saying, *"Are they clients of CMHA? Are they clients of SHCHC? Can [CMHA] see the records of the SHCHC workers? Can the SHCHC workers see [CMHA] records, or the Concurrent Disorders workers?"*

The divided oversight structure was described as slowing down access to funds. Case managers expressed dismay about the fact that funding was not available directly to SHCHC and that it was considered time consuming to go through a partner agency to access funds. The case managers explained that in certain situations they required immediate access to funds, for example, when offering a landlord first and last months' rent to secure an apartment for a client.

Case managers commented on the perceived inconsistencies in the relationship between the two agencies. One case manager stated, *"In the beginning the partnership and different staff roles were explained in one way, but there has been inconsistency in how that has actually looked."*

Both case managers and key informants commented on the challenges associated with offering truly integrated services. For example, it took time to integrate the ICM and housing services, and to foster effective collaboration between the housing coordinator and the ICM case managers. Several case managers and key informants spoke of confusion and lack of clarity over the housing coordinator's roles and responsibilities versus those of the case managers (e.g., whose duty is it to liaise with landlords?). Case managers also described feeling pressure to house clients early on in the program, but did not feel that they had the information or support to know how to act. With the increased number of clients and workload, case managers still felt like they needed to manage some of the work around housing issues.

In some instances, approaches and priorities conflicted between the organizations. For example, when a client had damaged an apartment, CMHA quickly paid for the repairs to maintain a positive relationship with the landlord. However, the client's case manager had developed a plan for the client to pay for these repairs that was not acted upon because CMHA quickly covered the costs, so this learning opportunity for the client was felt to be lost.

There was also some confusion regarding access to services. Case managers noted that their initial understanding was that program clients were not eligible to attend concurrent disorder groups organized by CMHA, but then case managers were being strongly encouraged by CMHA to enroll their clients in the concurrent disorder program. However, a key informant indicated that concurrent disorder services were always available for the program's clients and, in fact, funding for concurrent disorder services was always part of the program.

3.4.2 Program and Inner City Health

Some case managers and key informants discussed past tension that existed between the two agencies that arose from the difficulty in transitioning clients from Inner City Health and into the Supportive Housing for People with Problematic Substance Use program. Some clients struggled to adjust to the lower level of support provided by the Supportive Housing for People with Problematic Substance Use program, given that Inner City Health provided such a high level of support. Staff at both agencies recognized the need to work together to address this issue, and the relationship between the agencies consequently improved. In order to prepare clients for the change in services, the program works with staff from Inner City Health to prepare clients for the transition to the program. They engage in information sharing and knowledge transfer, and hold case conferences to discuss shared clients. They develop a consistent plan and set of goals, so they can work together to best transition clients.

3.4.3 Referrals

One challenge encountered with referring agencies was receiving inappropriate referrals. The difficulty was that the individuals who were referred would be approached for the referral process; however, if they were not appropriate for the program, then they would not be accepted, which could lead to disappointment on the part of the potential client and further deterioration of functioning.

3.4.4 Relationship between the program and landlords

While case managers and key informants recognized the importance of reaching out to landlords, they stated that the program could benefit from increased emphasis on this outreach, thus strengthening the relationship between the program and landlords. One case manager explained the importance of developing stronger connections with landlords and the need to "schmooze" them:

> *There's like a few companies, two companies, who we do that with, but as the program grows we really need to reach out to other people we haven't developed relationships with yet. I think that's what we're really lacking in is the landlord appreciation, landlord connections, stuff like that.*

Another case manager suggested that the program take a more proactive stance by reaching out to potential landlords to explain the program, answer questions, and determine ways of fostering a partnership.

3.5 Contextual

One contextual issue that negatively impacted the implementation of the program was waiting lists for services that clients required. Another contextual factor was uncertainty over the long-term funding of the program.

3.5.1 Waiting lists

Although clients might be ready to work on specific issues, a long waiting list for some services and the lack of other services make it difficult to work towards clients' goals. One case manager said:

> *I think access to mental health services as well, like counselling and things like that, sometimes you've got three or four month waiting lists and I think that's very difficult because when you're meeting your client at the level of readiness that they're at and then you have to let them know that they have to wait an additional three months to express themselves in a counselling environment, I think that's difficult as well.*

3.5.2 Long term funding and program sustainability

At the time of data collection, the current funding was reported by key informants to be sufficient to support the current number of clients, but there was question about the future. As the program increases in size, it was uncertain how the program would maintain access to subsidized housing for all future clients. As described by key informants and case managers, it is expected that clients will stabilize and no longer need ICM services, freeing up case management resources. However, current clients will maintain their rent supplements even after they transition out of the program. The concern is that rent supplements might not be available for new clients. Having clients without rent supplements would not be consistent with the program as described by the MoHLTC. It was also noted that a lack of rent supplements would be inconsistent with a Housing First approach. If clients enter the program without a rent supplement they will not have access to what is considered an important component by staff and key informants, or they may be housed in lower quality housing as their housing is not subsidized.

> *…in a couple years, we're going to have to start intaking clients, but not having a rent sup to give them. So, that's going to be, now we're not going to be Housing First purists anymore because we're going to have to find them substandard housing 'cause that's all they can afford.*

Once the funding for rent supplements becomes less available, there was also concern that clients who are not currently housed, or not using a rent supplement may not have access to a rent supplement in the future as they are not using one currently. There was also a lack of clarity about how clients who engage in behaviours that cause them to lose their housing might be further supported by the program (i.e., would they lose their rent supplement?) and

whether there were policies for clients who repeatedly lose their housing. It was also noted that there was discussion of a potential change in the approach in which a "three strikes rule" would be applied, meaning that clients might lose access to their rent supplements if their behaviour continues to be problematic and leads to multiple evictions.

Some wondered whether the funder understood that clients will still require a rent supplement even once they no longer use ICM services.

> *…for a lot of parts of the government, I think they think we give service for 4 or 5 years then they get closed, then they get closed out of the rent supplement, they go somewhere and we help an all-new batch of people.*

It was difficult to predict the future availability of rent supplements as the amount of the subsidy varies depending on the cost of the rent. It was also suggested that working with a finite number of rent supplements is consistent with how other case management programs operate.

If the program is no longer funded at all, there was concern about the impact, such as the clients becoming homeless again and returning to the emergency shelter system if they could not afford their rent. Other key informants were less concerned about losing funding as the negative impact of closing the program was perceived as so costly. Case managers reported different understanding of the length of the funding for the program. Another issue with funding was the cost of inflation in rent and utilities, as that was not thought to be accounted for in the funding.

4.0 What changes are suggested by stakeholders to improve the program?

In response to how the program should be further developed or improved, a number of specific suggestions were proposed by key informants, staff, and clients. The suggestions have been grouped into increasing program capacity, adapting case management delivery, access to resources, organizational policies, and addressing housing with future clients.

4.1 Increasing Program Capacity

To increase program capacity, evaluation participants' suggestions included increasing occupational and recreational components, further encouraging treatment, having access to phones for clients, and adding some other services.

4.1.1 Increasing occupational and recreational components

It was noted by several key informants that numerous clients have reached a greater level of stabilization. However, these clients can be lonely as they have lost connections with old friends who also had problematic substance use. Clients also have more free time as they no longer need to spend their day focusing on survival. Key informants and clients offered suggestions for developing new activities and relationships. Clients suggested having a drop-in designed solely for program clients to develop relationships with one another and offer peer support. Clients also suggested having activities offered for program clients in their residential

neighbourhoods as transportation was an issue. Suggestions from key informants included engaging clients in employment, volunteering, education, or connecting them with recreational services like the library or a community centre. One suggestion was having an employment readiness training subsidy. Engaging clients in occupational and recreational activities was seen as central by a key informant who stated: *"I don't think you truly integrate people through housing, I think you integrate people through work and occupation. I think that's where the real integration starts to happen."*

4.1.2 Further encourage treatment

A key informant stated that participation in concurrent disorders treatment groups appears to be quite beneficial for clients and thought that they should be encouraged to engage in treatment groups as soon as possible. Another option is to add tobacco cessation support for clients.

4.1.3 Access to phones

A key informant and clients suggested that the program would benefit from clients having access to phones. Currently, a number of clients do not have phones. Barriers include cost and clients indicated that phone companies have refused to offer them service. Since clients often do not have phones, case managers have to visit clients' apartments to have contact with them, as described by two clients:

> *Moderator: how does your worker get ahold of you?*
> *Client 1: She…hit and miss.*
> *Client 5: She drives by. Drive by. Hopefully, you're home.*

Thus, if clients had phones, case managers would be able to confirm with clients when they will be home for a visit. A key informant describes the importance of clients having phones:

> *Phones is the biggest single issue for the program. Because it wastes…I wouldn't say waste, but, you know, a case manager who has to drive to [apartment building] then to be told by a client, "No, I'm not in the mood," when they could have called and the client could have said that. The driving around the city's a huge burden, so phones for our clients.*

One client was quite concerned about not being able to reach his case manager's cell phone when the client was in jail. He suggested that case managers should have regular hours when they can be reached at a landline phone. This way, incarcerated clients could contact their case manager to address issues that need to be managed while the client is in jail.

4.1.4 Other services

One service that was suggested by a key informant would be to have outreach nurses who would visit clients at their homes. Having access to a van or truck to assist clients with their moves was identified as being a service that could be helpful.

4.2 Adapting Case Management Delivery

To further address client needs and to respond to changing caseloads as the program matures, suggestions included offering extended hours of services, offering services on-site, and redistributing the workload.

4.2.1 Extended hours

The case managers are available during the day from Monday to Friday; however, no one from the program is available outside of those times. Key informants suggested extended hours as a potential service that could be offered. A key informant noted that if case managers were available on evenings or weekends, they could further support clients with dealing with unwanted visitors, or further support recovery by offering more frequent visits.

> *So you often are doing lot of negotiations and encouraging people not to engage in this sort of disruptive behaviour on Friday nights. But well we're not here Friday night, there's no one to call necessarily to intervene. Would that be helpful… what happens if we have someone that works during weekends, or somebody that we can send to particular location, to really reinforce, people that are having trouble saying "no" to visitors, what kind of intensive service might be able to assist them by visiting more frequently, visiting at the times that people are more likely to be there, to assist them, to say here, you need some help.*

4.2.2 Services on-site

Since several clients reside in one location, one option would be to have a case manager assigned to be on-site regularly at the buildings where several residents live. Thus, that staff member could visit clients when on-site.

4.2.3 Reorganize case manager caseload

Key informant and case managers mentioned that they will have to reorganize the case manager workload as the program matures and clients require less intense support. One suggestion was to reorganize the caseload, so that one case manager works with the more stabilized, higher functioning clients and the caseloads of the other case managers could be reorganized when new clients join the program. Another option was to have the case managers take on special projects, such as a kitchen group, as their workload changes when clients stabilize.

4.3 Resources

Quicker access to financial resources could be helpful. For example, having access to money for a deposit for an apartment would help secure housing as clients can lose out on housing if they cannot quickly produce sufficient funds.

Case managers were concerned about the office space available to them. It made it difficult at times to find space to work or to meet with clients at SHCHC. Case managers noted that they would find increased office space beneficial. The current lack of space is described by a case manager:

It's just that when we were at four, when we were at six, it was a lot easier to manage the office space. Now we're at ten people with four cubicles. I don't think anybody in this… like people have single offices here or double. We're the only group that's, like, crammed.

4.4 Organizational Policies

The case managers were concerned about the financial impact of vehicle damage and depreciation as they use their cars throughout the day to visit and to transport clients. Case managers noted that they need to pay a deductible if they have a no-fault accident while working, and no-fault accidents can lead to an increased cost of insurance premiums. Case managers noted that they would find it helpful if there were policies around vehicles and vehicle damage.

4.5 Addressing Housing with Future Clients

Given that one of the major upcoming issues is the limited amount of rent supplement funding available, key informants and case managers were advocating for an increase in rent supplement funding.

Another suggestion was to adapt the program to work with individuals who are housed, such as tenants of Ottawa Community Housing, but who have problematic substance use and may be at risk of losing their housing. This potential approach is explained by a key informant:

So, you know, there's different opportunities that way to support people who are already housed and may be at risk of losing that housing. That could be, for example, that's an alternative Sandy Hill could look at if they want to go forward and they don't want to be working with people who don't have housing, to look at doing your intake from people who are at risk of losing their housing.

Summary

Overall, the program was perceived by stakeholders as having been successfully implemented as a Housing First model intended to serve adults with problematic substance use. The critical ingredients envisioned by the key informants and case managers were in place, including ICM support and housing. Clients were generally receiving rent supplements, allowing them access to higher quality housing than they would otherwise be able to afford.

Comparing the intended program and the actual program, the program is serving the intended population of individuals who were homeless, or at risk of homelessness, and had problematic substance use. In addition to a high level of substance use, clients were reported to have compromised health. At this time, the program is providing subsidized housing to most interested clients. All clients are receiving support from a case manager. Case managers have offered assistance with finding and maintaining housing, crisis counseling, and accessing other services. With involvement in this program, clients are able to access a range of other services, including health care and treatment for substance abuse (e.g., concurrent disorders groups and methadone maintenance treatment). Support for housing is also available through the housing coordinator. CMHA and SHCHC reported a good level of collaboration and efforts to work

together. The program had relationships with other agencies to support clients and to receive referrals for potential clients.

Despite this early implementation success, there is a realization by program stakeholders that there are finite resources dedicated to the program, creating uncertainty around the provision of subsidized housing. Other areas of challenge include the structure of the partnership between CMHA and Sandy Hill, developing landlord relationships, and clients' isolation.

Limitations

A limitation of the evaluation was that feedback from only eight clients was included in the evaluation. It may also be that clients who agreed to participate are those who view the program positively and their perspectives may not reflect the views of all clients.

Recommendations

Several recommendations are suggested. The first five are intended for the Ottawa Supportive Housing for People with Problematic Substance Use program. The sixth recommendation is addressed to the Ontario Ministry of Health and Long-Term Care. The seventh recommendation is addressed to the program and the MoHLTC.

Recommendation #1: Enhance vocational and recreational support

It was noted that as clients stabilize, they may benefit from involvement in structured activities, such as volunteer work, paid employment, or education and training. For clients who have reached a greater level of stability, dedicated services around vocational or educational support would assist clients in developing these types of activities which might alleviate the loneliness and isolation that was reported and could also facilitate integration into the community. The program could consult with a vocational specialist for these services. Another option would be to link clients to recreational activities in the community. Given the client-centered nature of the program, use of these services would be dictated by client choice.

Recommendation #2: Develop peer involvement within the program

Clients indicated an interest in further peer involvement. SHCHC was reported to have a plan to focus on peer programming, which would help to address this recommendation. One concern that was noted around peer involvement was that clients were trying to disengage from previous connections as part of their recovery; however, perhaps clients who are further along in their recovery could work within the program as peer support. Another way in which clients could be involved in the program would be to include clients on a program advisory board, so their perspective can be included in future program planning and development.

Recommendation #3: Clarify roles and responsibilities between organizations and between housing and support services

In the context of a new partnership, there is often a need to work out the roles and responsibilities of the different organizations and staff members. In this evaluation, the respective roles and responsibilities of the partner organizations were described as unclear at times. In particular, there was a lack of clarity about whether some aspects of the housing

support were to be done by the case managers or housing coordinator. In the Housing First model, the expectation is that housing is separated from support. However, this differentiation of responsibilities does not always seem to be the case in this program (e.g., case managers have assisted with housing paperwork, finding apartments). Working towards clarifying these roles and responsibilities would help the organizations to further understand and clearly delineate the partnership. It was our understanding that some progress has been made on clarify the responsibilities of the housing coordinator and case managers. However, we would recommend a review of the relationships and responsibilities in relation to housing, as well as formalizing and documenting the roles and responsibilities of the staff so future staff members can understand their roles.

Recommendation #4: Further engage landlords

The relationship with the landlords was seen as a key aspect of the program as the landlords allow access to housing. To further engage landlords, one option would be to hold periodic meetings with landlords to discuss the program. It is our understanding that the program plans to work on this area by further developing relationships with current landlords and reaching out to new ones.

Recommendation #5. Clarify policy on vehicles

Case managers were concerned about the impact of using their cars daily for work in terms of the financial cost. While appreciative of the coverage for mileage and parking, they were concerned about depreciation and the impact on their insurance costs. It has been noted that since data collection, this issue has been discussed by the ICM team. An accountant addressed the case managers to explain how to account for the use of their cars for work on their taxes.

Recommendation #6. Clarify availability of rent supplements for future tenants

One of the two main components of the program as identified by the Ministry of Health and Long-Term Care was access to subsidized housing, which is provided through rent supplements. While the number of rent supplements was sufficient for the current number of clients, there was concern that rent supplements would not be available for all future clients since clients maintain their rent supplement after leaving the program. If the expectation is that the program will continue to operate as originally envisioned, then further rent supplements are required. Otherwise, the program will need to adapt and not be following the Housing First model as consistently.

Recommendation #7. Secure finding for phones for clients

Currently, many of the program clients do not have phones. In order for the staff to contact clients, they have to drive to the client's home, which is very time-consuming. Another concern is that clients have limited means to seek assistance in an emergency. It is recommended that funding be secured so clients can have access to their own phones.

References

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Appendix A. Key Informant Interview Guide

Thank you for attending this interview. As you know, the purpose of this interview is for you to share your knowledge about key program components of the Ottawa Supportive Housing for People with Problematic Substance Abuse Program and their implementation. We believe that this is important because the findings of this research will inform other jurisdictions that are interested in implementing similar initiatives. The interview will take less than one hour.

Before we get started let's review the consent form. Then you can decide if you want to participate in the interview.

[Interviewer reviews the information letter and consent form with the participant.]

What questions do you have before we begin?

[After questions have been asked and answered, the participant is asked to complete the consent form and give it to the interviewer.]

I am now going to start the tape recorder.

The purpose of today's interview is to focus on the key program components of the Ottawa Supportive Housing for People with Problematic Substance Abuse Program. By components, I mean the critical ingredients of the services that are being delivered in the project.

1. Thinking about the project and your experience with it, how well do you think you know this program?

2. If you had to describe this program to a colleague, what are the most important aspects of the program that you would describe?

Probe about specific elements in the fidelity assessment tool.

3. What difference do you think the program will make for people who participate in the program? Will there be any benefits for other stakeholders (e.g., other programs or systems)?

Probe about short term vs. long term outcomes and anticipated timelines for their impact

4. What is it about the program that you think will produce the outcomes you have just described?

Probe: What specific activities, services, or supports are central to producing outcomes? How are consumers affected by these program components?

5. Thinking about how the program has been implemented in Ottawa, what, if any, have been the changes or adjustments that have been made to the program?

6. What other organizations or partners are needed to produce program outcomes you have described?

7. If you had more time, what could be added to the program, or improved?

8. What ideas do you have as to how the findings of the Ottawa Supportive Housing for People with Problematic Substance Abuse Program can be shared with others?

9. Are there any concerns about the sustainability of the program? If so, what can be done about these concerns?

Appendix B. Focus Group Interview Guide for ICM Staff

Thanks everyone for attending this voluntary focus group session. As you know, the purpose of this interview is for you to share your knowledge about the implementation to date of the Ottawa Supportive Housing for People with Problematic Substance Abuse Program. We believe that this is important because the findings of this research will inform other jurisdictions that are interested in implementing similar initiatives. The focus group will be no more than one hour to one and a half hours in length.

Before we get started let's review the consent form. Then you can decide if you want to participate in the focus group.

[Interviewer reviews the information letter and consent form with participants.]

What questions do you have before we begin?

[After questions have been asked and answered, participants are asked to complete the consent forms and give them to the facilitators.]

Let's begin by introducing ourselves to the rest of the group.

[After introductions have been made.] I am now going to start the tape recorder.

The purpose of today's discussion is to focus on the implementation of the Ottawa Supportive Housing for People with Problematic Substance Abuse Program. I will give everyone a chance to respond to each question. If you don't want to give your opinions or voice your experiences about the question, feel free to pass.

Fidelity Evaluation Issues

First, I'd like to ask you about the extent to which the implementation of the Ottawa Supportive Housing for People with Problematic Substance Abuse Program corresponds to the original plans.

Are there any discrepancies between planned and actual implementation of the Ottawa Supportive Housing for People with Problematic Substance Abuse Program? (If yes) What are they (housing? ICM services?)? Why are these discrepancies present?

Formative Evaluation Issues

General Formative Issues

Now I'd like to know your thoughts about which parts of the project are working well and which aspects are not working as well. What parts of the implementation of the Ottawa Supportive Housing for People with Problematic Substance Abuse Program do you think are working well?

Probe questions: What things have helped program implementation to go smoothly (e.g., service team, landlords, wider community, partnerships, research)?

What parts are not working well?

Probe question: What challenges and barriers have emerged as the program has been implemented (e.g., systemic issues, other organizations, landlords, team dynamics, leadership, human resources, etc.)?

Relationships

How well have housing services and service providers been working together?

- How have working relationships evolved since the beginning of the project?
- Is there anything that needs to be addressed to improve working relationships?

What other stakeholders have been involved in the implementation process and in what capacity?

Consumer Involvement

Next, I'd like to ask you to talk about the role of consumer participation in the implementation of the project.

1. How have people with lived experience participated in the implementation of the project?

2. What has facilitated the involvement of people with lived experience? What barriers have there been to this involvement?

Structures

What organizational structures at Sandy Hill Community Health Centre are in place to provide direction and assistance with the implementation the Ottawa Supportive Housing for People with Problematic Substance Abuse Program? How well are they working?

Probe about regular meetings

Probes: What aspects of the organizational structure at Sandy Hill facilitate the implementation of the Ottawa Supportive Housing for People with Problematic Substance Abuse Program? What aspects impede this implementation?

Resources

What resources have been important for successfully implementing Housing First /ICM services?

Probe questions: What qualities and skills do you think are critical for the staff who do this work? How is the sustainability of the program being addressed?

Developmental Evaluation Issues

Next, I'd like to ask you about the ways that the Housing First/ICM program has changed, developed, or adapted over the course of its implementation so far.

1. What has been done (if anything) to adapt the program to the local context?

2. What are the key factors in the program's environment, such as the larger community and network of services, that are influencing its successful implementation? (e.g., broader system/policy changes, resources, team dynamics, leadership, etc.)

3. Describe how any new program innovations, if any, have resulted from changes over time?

Ending the Interview

Are there any other perceptions about the program you haven't had a chance to mention you would like to add before we finish up?

As I bring this focus group to a close I would like to know about your experiences (how you feel, what you are thinking) about having participated today/tonight. What was it like for you to participate in this focus group?

Appendix C. Focus Group Interview Guide for Consumers

Thanks everyone for attending this voluntary focus group session. The purpose of this group is for you to share your experiences about the services that you are receiving, or have received, in your community. This research is part of the Ottawa Supportive Housing for People with Problematic Substance Abuse Program. It will help us to understand the services that are currently available in your community, what you believe works well, and what could be improved. The focus group will take about one hour to one and a half hours.

Before we get started, let's review the consent form. Then you can decide if you want to participate in the focus group.

[Interviewer reviews the information letter and consent form with participants.]

What questions do you have before we begin?

[After questions have been asked and answered, participants are asked to complete the consent forms and give them to the facilitators.]

Let's begin by introducing ourselves to the rest of the group.

[After introductions have been made.] I am now going to start the tape recorder.

The purpose of today's discussion is to learn about your experiences accessing services in your community. I will give everyone a chance to respond to each question. If you don't want to give your opinions or voice your experiences about the question, feel free to pass.

1. What type of services are you currently receiving, or have you received, in this program and in this community?

Potential probes:

a. What is that program like?
b. What group provides that service?
c. Where do you go to access that service?

2. What things are helpful about the services you are receiving or have received? Why are these things helpful? How have they helped you in your recovery?

Probe for:

a. Accessibility issues (e.g. location, hours, language)
b. Quality issues (e.g. helpful people, comfortable setting)

3. What things are not helpful about the services you are receiving or have received? Why are these things not helpful? How have they not helped your recovery?

Probe for:

a. Accessibility issues (e.g. location, hours, language, rules/barriers that get in the way of receiving services)

b. Quality issues (e.g. unhelpful people, uncomfortable setting, feelings of judgment or stigmatization)

4. What do you think should be changed about the services available in this program and in this community?

Potential probes:

a. Are there any services that are not currently available that you think would be helpful?
b. How could the services you are receiving from the Ottawa Supportive Housing for People with Problematic Substance Abuse Program be improved?

As I bring this interview to a close I would like to know about your experiences (how you feel, what you are thinking) about having participated today/tonight. What was it like for you to participate in this interview?

Is there anything we could do to improve the interview?

I am now shutting off the tape recorder.

What questions do you have of me?

Thank you very much for your participation in this interview. I appreciate your willingness to share your experiences with me.