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The At Home/ Chez Soi Project:

Sustainability of Housing & Support Programs Implemented at the Montreal Site

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LIST OF ACRONYMS

ACT	Assertive Community Treatment
AHCS	At Home/Chez Soi
CHUM	Centre hospitalier de l'Université de Montréal
CIUSS	Centre intégré universitaire de santé et de services sociaux
CoC	Continuum of care
CREMIS	Centre de recherche de Montréal sur les inégalités et les discriminations
CSSS	Centre de santé et de services sociaux
FOHM	Fédération des OSBL d'habitation de Montréal
FRAPRU	Front d'action populaire en réaménagement urbain
HF	Housing First
HN	High needs
HPS	Homelessness Partnering Secretariat
ICM	Intensive Case Management
IUSMM	Institut universitaire en santé mentale de Montréal
MHCC	Mental Health Commission of Canada
MMFIM	Mouvement pour mettre fin à l'itinérance à Montréal
MN	Moderate needs
MSSS	Ministère de la santé et des services sociaux (i.e. Quebec's Ministry of Health)
NP	Non-profit
OMHM	Office municipal d'habitation de Montréal
OSBL	Organisme sans but lucratif
PECH	Programme d'encadrement clinique et hébergement
PRISM	Projet réaffiliation en itinérance et santé mentale
PSL	Programme de supplément au loyer
RACOR	Réseau Alternatif et Communautaire des Organismes en santé mentale
RAPISM	Réseau d'aide aux personnes seules et itinérantes de Montréal
SHDM	Société d'habitation et de développement de Montréal
SHQ	Société d'habitation du Québec
SII	Suivi intensif en itinérance
TAU	Treatment as usual

KEY MESSAGES

The aim of this report is to tell the sustainability story of the Housing First (HF) services that were established during the At Home/Chez Soi (AHCS) project in Montreal, after its official closure in March 2013. To understand Montreal's AHCS sustainability story, individual in-person semi-structured interviews (n=9) were conducted in May and June 2015 with key stakeholders from the AHCS project.

Montreal was one of the five Canadian cities selected for implementing the AHCS project, a randomized controlled trial funded by the Mental Health Commission of Canada (MHCC), designed to measure the effects and benefits of HF on adults experiencing homelessness and a severe mental illness. In total, 469 participants were recruited in Montreal between October 2009 and May 2011. Following a baseline interview, participants were randomly assigned to a treatment group (n=286) where they received an HF intervention, or to a treatment as usual group (n=183) in which already available services were maintained.

In February 2013, two months prior to the official end of the MHCC subsidy to AHCS, the *Agence de la santé et des services sociaux de Montréal* (to which we will refer as the "*Agence*" henceforth in the text), the agency overseeing health and social services in Montreal, announced that it would not be picking up the funding of AHCS after the end of the MHCC's subsidy and that all participants would be transitioned to usual services by the end of the project on March 31, 2013. All clinical teams were to be dismantled, casting doubts upon the sustainability of HF in the province of Quebec.

When the interviews with key stakeholders were completed, two years after the project's end, the outlook was more positive: HF was far from being fully recognized and integrated in Quebec's health and social service system, but public discussion had gradually shifted, among more stakeholders than before, from the political controversy of HF to recognition of its potential contribution as part of an overall response to homelessness.

One ICM team from the AHCS project, Diogène, managed to obtain funding for a full team and continued to provide services to former AHCS clients, including some clients from two other former teams of the AHCS project who were dismantled. HF is now identified in the provincial government's homelessness action plan as one of the valid approaches to helping persons who are chronically homeless and living with a severe mental illness. The reorientation of HPS funding towards HF has incited many organizations to adopt this approach, such as the three largest shelters in Montreal who formed a consortium to deliver HF services.

Stakeholders identified various factors that influenced sustainability : the difficulty of providing ongoing training and feedback in Quebec, local advocacy groups publicly opposing and also lobbying against the project, the opposition of the *Agence* – exacerbated by tensions between the provincial and federal governments – the discordance between the HF model and many community organizations' philosophy, a misunderstanding of the model among many key players in community organizations and government agencies, and a difficulty to sell HF at the onset of the project in Montreal.

Stakeholders also identified factors that contributed to the HF model's implementation and public recognition, such as research results, the creation of a new lobbying group called the Movement to End Homelessness in Montreal, which identified HF as a key approach to end chronic homelessness, and the recognition of HF in the provincial government homelessness action plan.

EXECUTIVE SUMMARY

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Montreal was one of the five Canadian cities selected for implementation of the AHCS project, a randomized controlled trial funded by the Mental Health Commission of Canada (MHCC), designed to measure the effects and benefits of HF on adults experiencing homelessness and a severe mental illness. In total, 469 participants were recruited in Montreal between October 2009 and May 2011. Following a baseline interview, participants were randomly assigned to a treatment group (n=286), or to a treatment as usual group (n=183). Participants in the treatment group received support from a clinical and a housing team, as well as a rent supplement. Participants in the treatment as usual group continue receiving the services provided through community organizations and the formal mental health system.

Sustainability Story

In December 2012, a little over three months before the official end of the AHCS pilot project, teams were receiving informal signals from the *Agence de la santé et des services sociaux de Montéal*, (the agency then overseeing health and social services provision in Montreal) that led them to believe that the funding of the clinical teams, housing teams and participants' rent supplements would be maintained after the project's official end in March 2013. A few weeks later, however, the situation shifted drastically: the *Agence* announced that all participants would be transitioned to usual services by the end of the project and that all teams were to be subsequently dismantled, while keeping all participants stably housed and linked to usual services, if need be.

In December 2013, despite the transitioning efforts, 131 participants were still housed in an AHCS apartment, a number still far from the *Agence*'s objective. The strategy deployed by the *Agence* to keep everyone housed and linked to clinical services led to some mixed results. In many instances, participants lost their clinical services and subsequently their apartment (or in reverse order). In some instances, participants were transferred to highly motivated and creative teams interested in learning from the AHCS experience and applying the project's core principles, who would continue providing

services regardless of the conditions, even if the participants lost their housing. Unfortunately, those teams were only able to add a limited number of persons to their caseload. On the other hand, many participants were transferred to teams who were not able to provide the same level of support as AHCS teams, thus putting in jeopardy the participants' recovery and residential stability.

When the interviews with key stakeholders were completed a little more than two years after the end of AHCS, the outlook was somewhat positive towards the HF model; while it was far from being fully recognized and integrated in Quebec's health and social service system, public discussion had gradually shifted from the political controversy of HF to recognition of its potential contribution as part of an overall response to homelessness. With the reorientation of HPS funding, many organizations are officially embracing HF, albeit not without some difficulties in terms of training and fidelity.

In parallel with the transition, and since the end of the AHCS project, stakeholders had been negotiating with the Office municipal de l'habitation de Montréal (OMHM) to obtain rent supplements. The OMHM agreed to provide all participants still housed in December 2013 with emergency rent supplements until 2019, funded through a pre-existing program intended for tenants experiencing financial difficulties and at risk of losing their housing. A new housing team was created at the CLSC des Faubourgs (formerly a part of the CSSS Jeanne-Mance) to serve as an intermediary between landlords, participants and clinical services, and to ensure that former AHCS participants remain stably housed.

Sustainability Outcomes

Despite initial opposition towards the AHCS project, the Government of Quebec ultimately acknowledged the potential contribution of HF in the province in its "Mesure 11.5," *the Plan d'action interministériel en itinérance 2015-2020* explicitly puts forward Housing First as a desired means of helping homeless people exit homelessness (Government of Québec, 2014). Many organizations in Montreal, including the three largest men's shelters, will be providing an HF intervention, funded by the HPS reorientation.

Even if two of the clinical teams established during the AHCS project were dismantled following the closure of the project, Diogène, a community organization who provided an ICM team to the project, ultimately managed to keep a team fully funded for an indefinite duration by advocating and negotiating with the *Agence*. In the summer of 2014, its size was increased back to five case managers and it has even taken on board some participants from the other AHCS disbanded teams. This organization's objective is to maintain in their totality the components of the HF model: the technical

elements as well as the philosophy of practice. With the potential HPS funding, Diogène hopes to be able to shift gears and house 100 new clients. They are planning on recruiting those via referrals from various organizations, either in the formal mental health system or among community organizations, and have developed formal partnerships with them. Moreover, the majority of landlords associated with AHCS remained on board and continued housing participants after the project's end.

The AHCS project also had multiple impacts and influences on various organizations, especially in Montreal. Teams were created by formal mental health institutions in partnership with community organizations, which were inspired by the AHCS experience, such as the SII team, designed to help and support persons who are homeless and living with a psychotic disorder to obtaining housing.

The practices that were developed and emerged during AHCS were documented. These "practice stories" are used to inform other actors who offer services to homeless people, either in the formal health system or in community organizations. They sparked great interest and stakeholders report being frequently asked to present them to groups or organizations who want to adopt them. According to one stakeholder, the report detailing the practice stories won the 2014 prize for the best innovative practices developed in the Quebec health and social services network.

The relative indifference in which the AHCS project was ending shocked many stakeholders, who realized the necessity of having a group that could exert leadership in Montreal. Concerned stakeholders founded a group dedicated to finding and promoting solutions to end homelessness in Montreal in a short span of time: the Mouvement pour mettre fin à l'itinérance à Montréal (MMFIM). At the moment of writing this report, the MMFIM has already had a considerable impact on Montreal's homelessness policies.

Factors Influencing Sustainability

Even if HF is now being implemented by a growing number of organizations, stakeholders generally express concerns regarding the difficulty of providing ongoing training and feedback in the province, which could jeopardize HF sustainability. One of the main obstacles to providing training is Quebec's Ministry of Health and Social Services, which has not allowed the MHCC to provide any kind of training in the province, arguing that they already have at their disposal the necessary expertise to do so.

The Montreal AHCS project met from the start with significant opposition from community organizations and groups at one level and from the provincial government at another level. The arguments that were then invoked against the project – the provision of public funds to private landlords via rent supplements, the implicit devaluing of existing and well-established programs and the perception that HF aimed to displace them all, the encroachment by the federal government into an area of provincial jurisdiction – all continued to fuel opposition to the model after the end of the project. Some stakeholders mention that the project had, from its outset, difficulties in selling itself. Some blunders, quite unintentional, offended key actors amongst various organizations working with persons that are marginalized or homeless.

The majority of stakeholders identified RAPSIM, one of Montreal's most prominent activist and advocacy groups, as the standard bearer that systematically advocated against AHCS and HF over the media, internet, in public events, in research events and in the bulletins and reports that they publish on a regular basis. Stakeholders report that RAPSIM would frequently send members or representatives to scientific conferences where AHCS representatives were speaking to speak against HF and AHCS. This organization also lobbied the government and other influential organizations against AHCS. The majority of the stakeholders stated that RAPSIM presented a narrow and incomplete vision of HF and AHCS. It misinformed its members, staff of community organizations and the general public.

Resistance to AHCS also came from the *Agence*; it was far from being supportive of the project and stakeholders mention that they had many difficult meetings with representatives of this organization and that it sometimes appeared like they were only trying to hinder the project.

The philosophy of practice of community organizations and the formal mental health system was pointed out by many stakeholders as one of the obstacles to the dissemination of HF. The Continuum of Care (CoC) approach is deeply entrenched in the practices and philosophy of the vast majority of organizations in Quebec. Many had never heard about HF before and were intuitively opposed to it. In their view, it is irresponsible to give an apartment to a person who is experiencing mental health problems and substance abuse disorders and that they perceive as not stabilized and housing ready.

Stakeholders mention that the HPS reorientation has both positive and negative impacts. On the positive side, the reorientation is inducing organizations to adopt HF and re-inserting the approach into public debate. Very recently, it has started to make its way into many organizations, even some that were rather hostile or doubtful when AHCS began. On the negative side, HPS reorientation has crystallized the opposition to the HF model and generated considerable discontent and tensions, especially in the regions outside Montreal where homelessness often takes a different form than in the

city. Stakeholders point out that we have never really measured the impacts of many programs that have ceased to be funded in the rest of the province in the wake of the HPS reorientation. This could have dire, unexpected consequences for the very individuals that HF is trying to serve.

INTRODUCTION

The aim of this report is to tell the sustainability story of the Housing First (HF) services that were established during the At Home/Chez Soi (AHCS) project in Montreal, after its official closure in March 2013. It also focuses on sustainability outcomes of the HF model and underlines the barriers and facilitators that were met in sustaining HF in Quebec. It also addresses the broader impact of the project on service delivery in Montreal, and even, as we will see, in France and Belgium. The report will broaden the comprehension of implementation and sustainability outcomes of the HF model in the Quebec context and can guide and enrich the discussion around further implementation and dissemination of this model in the province.

CONTEXT

The goal of this section is to give an overview of the various actors and organizations involved in the demonstration phase and in the analysis presented in this report, as well as some indications on political context prevailing during that period. A broader and more exhaustive description of the services offered to persons who are homeless in Montreal and of the implementation story of the AHCS project are presented elsewhere (Fleury et al., 2012; Fleury et al., 2014).

Montreal was one of the five Canadian cities selected for implementing the AHCS project, a randomized controlled trial funded by the Mental Health Commission of Canada (MHCC), designed to measure the effects and benefits of HF on adults experiencing homelessness and a severe mental illness. The initial implementation context in which this project was launched in Quebec, in 2008, seemed on the surface favourable and promising (Fleury et al., 2012), since homelessness had drawn a lot of public and media attention and was the subject of a parliamentary commission. The report this commission produced served as the basis for the *2010-2013 Inter-Ministerial Action Plan*, which emphasized the use of best practices to help people facing homelessness and mentioned HF as one of the practices to explore. The AHCS project, however, rapidly generated opposition from community groups as well as the provincial government. Some community organizations criticized the way the project would allocate funding, since part of it would go to private market landlords via rent supplements, while social housing and already existing services were in dire need of financial resources. The fact that study participants were potentially randomized to services as usual was thought to create false hopes and disappointment for those not receiving HF; this too generated some criticism. The uncertainty around the project's funding after 2013 was presented by some organizations as an unsustainable solution to homelessness, as well as a waste of resources that could

have been put to better use elsewhere to offer permanent housing. Moreover, many community organizations felt that the MHCC was dismissive of the services they were offering and implicitly if not explicitly describing them as inadequate, presenting HF as a one-size-fits-all solution that could replace everything already offered. Quebec's Health and Social Services Ministry (MSSS) as well as officials concerned with intergovernmental affairs indicated that they were displeased at the federal government intruding in an area of provincial jurisdiction.

At the onset of the AHCS project, the most recent estimate of the number of people who were homeless over the course of a year in Montreal was 12,666 (Fournier et al., 1998). Physical and mental health issues as well as substance abuse are much more prevalent among homeless persons than in the general population (Frankish et al., 2005). Most of the homeless services in Montreal such as shelters, transitional housing, drop-in centres, day centres and soup kitchens are provided by community organizations and concentrated in a downtown borough, Ville-Marie, where the homeless population is larger and more visible than anywhere else in the city (Latimer et al., 2015). While some of the women's shelters are also located in the Ville-Marie borough, many are scattered across the city, sometimes in confidential locations. Most of the community organizations offering services to homeless persons or persons in need are affiliated to, or members of, very well organized advocacy and lobby groups, such as RAPSIM[1], RACOR[2] and FOHM[3], that are well known by media and politicians and that have enough political weight to influence policy makers.

In Montreal, many government agencies also address homelessness in different ways, while none are specifically dedicated to it (Fleury et al., 2012). The Ministère de la Santé et des Services sociaux (MSSS) was until April 1, 2015 supervising regional agencies (*Agence*s de Santé et des Services sociaux), which provide funding and orientation to health and social service providers in their respective jurisdictions. In February 2015, the Government of Quebec enacted Bill 10, which completely overhauls the health and social service network in Quebec. One of the effects is the dissolution of all of the *Agence*s *de la Santé et des Services sociaux* and merging of health and social service providers, creating large administrative structures operating directly under the MSSS. As one of the goals of this new law is to reduce the size of the health system administration, many senior managers, including some who have been involved in the AHCS project, were transferred or decided to retire. At the time when this report was written, the effects of Bill 10 on the health and social service network have not been fully played out and the reorganization is still underway. The effects of the reorganization on the

[1] Réseau d'aide aux personnes seules et itinérantes de Montréal

[2] Réseau Alternatif et Communautaire des ORganismes en santé mentale de l'île de Montréal

[3] Fédération des OSBL d'habitation de Montréal.

sustainability of HF in Quebec cannot yet be determined. Regional (Montreal island) responsibility for overseeing health and social services for homeless people remains centralized, within one of the new large organizations, the Centre intégré universitaire de santé et de services sociaux (CIUSSS) du Centre-Sud-de-l'Île-de-Montréal.

At the time of the AHCS project, there was one *Agence* for the entire Island of Montreal. The Centre de santé et de services sociaux (CSSS) Jeanne-Mance was one of the units that the *Agence* oversaw and was responsible for the population, among others, of the centrally-located Ville-Marie borough. It had an extensive experience with homelessness and had developed many specialized programs designed to help homeless people. Housing subsidies and social housing are administered province-wide by the Société d'habitation du Québec (SHQ) and in Montreal with the partnership of the Office municipal de l'habitation de Montréal (OMHM) and the Société d'habitation et de développement de Montréal (SHDM). The social housing sector provides around 58,000 social housing units in Montreal, some of them dedicated to persons who are homeless (Ville de Montréal, 2014). A large variety of organizations provide social housing: government-run affordable housing offers 21,555 units, the City also provides 6759 affordable units, managed by the OMHM and the SHDM. Non-profits (NPs) offer 16,105 units[4] and there are 13,640 units in housing cooperatives. The OMHM also subsidizes around 9,000 rents in the private sector each year, through supplements referred to as programme de suppléments au loyer (PSL) (Ville de Montréal, 2016), a program created in 1978 (Habitation Québec). These rent supplements are attached to a particular apartment or housing unit, which has been inspected by the OMHM and must meet certain standards. They provide a means of increasing the availability of subsidized housing, without expensive capital investment. They are not designed to follow an individual as they move from one location to another.

In comparison with other cities where the AHCS project was implemented, Montreal's homeless population had no known salient features, such as a particularly high percentage of persons from First Nations (Winnipeg) or very high rates of substance use (Vancouver). Montreal's organizations involved in the initial discussion around the AHCS project made the argument that there was a strong tradition of social housing in Quebec that set the site apart from others in Canada[5]. Montreal's investigators

[4] Community organizations (NPs) offer short, medium and long-term congregate housing units for people in need (Ville de Montréal). They are generally specialized, intended for persons with similar demographic and/or health characteristics (e.g. youth, women, young mothers, people with mental illness, substance abuse issues or HIV/AIDS, etc.).

[5] During the consultation stage prior to the launch of AHCS in Montreal, many community organization representatives claimed that there was a social and community housing tradition in Montreal that was stronger than in other Canadian cities, that they labelled the "*Modèle québécois*" ("Quebec Model").

adjusted the study design to take these recommendations into account and established a third arm in which participants would be assigned to social housing.

The CSSS Jeanne-Mance, which had been playing a central role in the provision of health and social services to homeless people in Montreal, agreed to organize and manage an ACT and an ICM team for the Montreal site of AHCS. The community organization Diogène, which had been providing services to people experiencing mental health issues and homelessness since 1988, also agreed to organize and manage an ICM team for AHCS. The Douglas Mental Health University Institute provided the housing team for the project, which worked with all three clinical teams to find suitable apartments for their clients and help them keep them or, if need be, find other ones, thereafter. The project site coordinator was also based at the Douglas Mental Health University Institute and she also served as the manager of the housing team. In addition to the project site coordinator and the housing team managing the apartment stock, the research team recruiting participants and conducting interviews were based at the Douglas Mental Health University Institute.

In total, 469 participants were recruited in Montreal between October 2009 and May 2011. An algorithm based on criteria including level of functioning, diagnosis, substance abuse, previous hospitalizations and incarceration history, stratified participants to a group based on the level of need at the end of the baseline interview, either high need (HN) or moderate need (MN) (Goering et al., 2011). A third of MN participants (n=102) were assigned randomly to a treatment as usual group (TAU), where they continued receiving services already provided by various agencies or community organizations. Another third (n=104) were randomized to a group where they received HF services from an ICM team provided by Diogène, while the remaining individuals (n=100) received services from an ICM team provided by the CSSS Jeanne-Mance. Among the MN participants receiving HF services, half (chosen at random from among both the CSSS Jeanne-Mance and Diogène groups) were to be housed in social housing units[6] to reflect Montreal's alleged specificity in this domain, while the other half were to be housed in private market scattered-site apartments. Half of the HN participants (n=82) were randomized to a TAU group, while the other half (n=81) received HF services from the CSSS Jeanne-Mance ACT team and were assigned to receive a scattered-site apartment of their choice.

[6] Even if this was planned in the original research design, social housing units were never made available in sufficient numbers or those that were made had rules that would not allow housing of tenants with complex issues, such as substance abuse, or the units seemed unattractive (e.g., too small, too many rules) to AHCS participants. In the end, only six units were ever made available and almost all the participants were housed in private market scattered-site apartments. Randomization between social housing and private market apartments was abandoned several months after the start of recruitment.

Another significant actor was involved in the AHCS research: the Centre de recherche de Montréal sur les inégalités sociales et les discriminations (CREMIS), based at the CSSS Jeanne-Mance. The CREMIS is a research centre with a particular interest in social inequalities and citizenship and one of its mandates is to develop innovative practices in close collaboration with practitioners, administrators, and other members of the health and social service network. During AHCS, it focused on the analysis of qualitative interviews conducted with AHCS participants. With separate funding, a member of the AHCS investigator team documented and analyzed “stories of practice” from the case managers, which can now be used to inform case managers' practices. It also studied the impacts of the integration of peer support workers in the project.

METHODS

Sample Description

Nine semi-structured, in-person interviews were conducted with Montreal AHCS project key stakeholders (current or former clinical and housing team leaders, site coordinator, investigators and peers). One of the former clinical team leaders declined to complete an interview, while two other stakeholders from government agencies did not reply to requests to complete an interview.

Procedures

Individual, in-person, semi-structured interviews were conducted in May and June 2015 by the first author, who served as Montreal's research coordinator from the summer of 2013 onwards. The interviews were conducted in French and the interview guide provided by the national team was translated from English to French by the research coordinator. Montreal's lead investigator validated the translation. The recordings were transcribed by a professional and analyzed by Montreal's research coordinator. Montreal's lead investigator reviewed and corrected the report. The research was approved by the Douglas Mental Health University Institute Research Ethics Board. Participants signed a consent form explaining the details of the study before being interviewed.

Montreal's research coordinator had already had many contacts with all the interviewees, as he had been working as a research assistant/interviewer during the first phase of the AHCS project in Montreal[7] and as a research coordinator during the AHCS extension study. In some instances, this could have led to a reduction in the richness of data, as the interviewees and the interviewer shared a common history in the project as well as common interpretations in many instances. This created some risk that the interviewer would not sufficiently probe interviewees, either because the content of the interview was very familiar or because the interviewee would sometimes refer to politically charged events as "well, you were there, you know what happened." To mitigate this risk as much as possible, the interviewer made an effort to put himself in the situation of an outsider and to question the representations that the interviewees made when they referred to events that they assumed the interviewer was well aware of.

[7] The research team, the ACT team, one of the ICM teams and the AHCS Montreal site coordinator worked in the same office suite and were frequently in contact throughout the project – until the end of March 2013.

The HF fidelity assessment questionnaire was translated from English to French by the research coordinator. Montreal's lead investigator validated the translation. It was sent to the Diogène ICM team supervisor, who agreed to complete it with her team. The fidelity evaluation was completed in May 2016. The team supervisor completed the questions and validated the answers with the whole team, until an agreement was reached on each item.

Coding and Analysis

The data from the transcripts were analyzed using ATLAS.ti 7 qualitative analysis software. The analysis involved reading the verbatim and coding section of the verbatim that corresponded to themes that were identified in a template provided by the national level. Those themes were then regrouped and further analyzed. In some instances, these themes were refined into more precise sub-themes. Other themes specific to Montreal were also identified and analyzed.

The results are reported in a way that preserves the anonymity of all stakeholders as much as possible. Since stakeholders who completed the interviews are all highly specialized, no details are given about their specific position in the AHCS project. The excerpts are selected and transcribed in a way that is intended to prevent identifying the respondent.

FINDINGS

Montreal AHCS Sustainability Story

Overview: In December 2012, a little over three months before the official end of the AHCS pilot project, teams were receiving informal signals from the *Agence* that led them to believe that even if the project was generating controversy, the clinical and housing teams as well as housing subsidies would be maintained in their totality. A few weeks after that, however, in mid-February, the situation shifted drastically. The *Agence* announced that all participants would be transitioned to usual services by the end of the project on March 31 and the teams were to be dismantled.

This generated a high level of stress and confusion for everyone involved in the project, especially for the participants who felt that their housing stability would be jeopardized. The teams were not completely caught off guard by this order, since they had been working on a transition plan for more than a year. But even if they worked around the clock, it would have been impossible to transfer about 200 participants within six weeks. Faced with arguments that this period was much too short to successfully transition so many individuals, the *Agence* relaxed its timeline, but the objective remained to transition all participants to usual services as quickly as possible. The CSSS JM teams, which had assembled between them 16 case managers, were to be completely dismantled after being temporarily transformed into a single transition team of four case managers in April 2013. The same was true of the Diogène team, though in that case a team of six case managers was cut by two-thirds, to two case managers.

When the interviews with key stakeholders were completed a little more than two years after the end of AHCS, the outlook was more positive; HF was far from being fully recognized and integrated into Quebec's health and social service system, but public discussion had gradually shifted, among more stakeholders than before, from the political controversy of HF to recognition of its potential contribution as part of an overall response to homelessness. Despite the February 2013 instructions from the *Agence* to transition all participants to regular services, the Diogène team continued to provide HF services to its remaining participants. In the summer of 2014, its size was increased to five case managers and it had even taken on board some participants from the other disbanded teams. A new housing team had been created at the CLSC des Faubourgs (formerly a part of the CSSS Jeanne-Mance) and with the reorientation of HPS funding, many organizations were officially embracing HF, albeit not without some difficulties in terms of training and fidelity. The OMHM had committed to provide emergency housing subsidies (PSLs) to all participants still housed in scattered-site AHCS apartments. This period was intended to be sufficient to relocate most of the participants into different

forms of stable, affordable housing. Moreover, fruitful research partnerships with other French-speaking countries such as France and Belgium that are also implementing HF, have indirectly led to a growing recognition and acceptability of the model in Quebec. The following sections provide a more in-depth account of the sustainability story.

Diogène ICM team – From Diogène Chez Soi to Diogène Un Toit d'abord. As mentioned above, the Diogène ICM team, like all other organizations involved in the project, received in February 2013 the order to transition all participants and to gradually dismantle the team. It was clearly not realistic to transition everyone between February 2013 and April 2013. Therefore, the *Agence* provided enough temporary subsidies to fund two case managers that would be solely responsible, after the end of the project, for transitioning participants to usual services and to find them social housing (or any other affordable housing), over a six-month period. AHCS participants' rent supplements were during that period covered by the MHCC, which extended the rent subsidies by one year after the official end of the project in Québec.

Some participants, especially those who now seemed less in need of support, gradually ceased to receive services from Diogène. Their follow-ups would get more and more spaced over time, until the participant felt comfortable enough to go on without the clinical team's support.

Even with an extended period of time dedicated to the transition, it quickly became apparent that it would be hard if not impossible for Diogène to transition all its participants successfully, for two main reasons. First, as a community organization, Diogène could not fast-track its participants into the formal mental health system (e.g. other ICM teams, social workers, case managers or other specialized services). Moreover, the clients they were serving were considered "too heavy" for other community organizations with less funding and who had no experience in providing HF-like services or whose mandate did not correspond to people with multiple issues as Diogène's clients typically had. Diogène rapidly decided to maintain its ICM team as intact as possible and abandoned the project of transitioning its participants to other services, while advocating and negotiating with the *Agence* for more funding. They managed to keep some case managers from the original team by temporarily transferring them to the regular Diogène ICM team. During the same period, the transitioning of the participants from the CSSS Jeanne-Mance teams was taking place and many of them were being referred to the regular Diogène ICM. In other words, as one of the stakeholders put it, "the people who were being pushed out through the door were coming back in through the window."

That situation, demonstrating that Diogène was still necessary to help participants remain housed, was in itself a strong argument and after frequent meetings with the *Agence*, which was now becoming

increasingly aware of the difficulties that arose from transitioning the participants to usual services, Diogène managed to obtain temporary funding for four case managers until December 2014. After another round of fruitful negotiations, they obtained permanent funding for five case managers, to continue providing an HF intervention. All the case managers on the payroll were part of the original team that was founded in 2009 at the beginning of the AHCS. Diogène had to remove from their branding any direct reference to the AHCS project or the MHCC. Diogène Chez Soi thus became Diogène Un Toit d'abord, which is an untranslatable pun; it literally means “Diogène A Roof First”, but if the article is ignored, it sounds exactly like Diogène Toi d'abord, “Diogène You First.” Taken together, the two meanings clearly signify their commitment to continue offering HF services. At the time when the interview was conducted, Diogène was still serving 55 clients from the original AHCS project (including participants transferred from other teams) and applying for a grant from HPS to provide HF services to 100 new clients and were looking to hire new case managers, some from former AHCS teams.

Stakeholders also indicate that Diogène never completely discharges participants. When they stop receiving services and are transitioned elsewhere, their file remains in "hibernation" and can be reopened at any time, if need be, regardless of their housing situation. This was very beneficial for some who lived through difficult experiences after they officially stopped receiving services and were transitioned elsewhere. Diogène often stepped in a few months later to help participants keep their housing (provided that the participant agreed to this).

CSSS Jeanne-Mance ICM and ACT teams – dismantling the teams. The CSSS Jeanne-Mance team had to transition participants from both an ACT and an ICM team before being completely dismantled. The participants from the former were more difficult to transition, as they had, due to the original criteria for assignment to the two teams, greater needs to begin with. Stakeholders report transitioning many of them to more intensive services or other forms of residential care facilities, such as long-term care facilities, psychiatric hospitals, group homes or other forms of congregate housing with on-site support. Approximately ten participants served by the AHCS ACT team, as well as three case managers and one supervisor from this team, were transferred to the ACT team of the Centre Hospitalier de l’Université de Montréal (CHUM) after the end of the project. These participants were those who were thought by the team to present the highest degree of challenge and difficulty and who could not, for one reason or another, be transferred to other types of services.

Those considered more advanced in their recovery were transitioned to usual services and remained in their AHCS apartment. The service providers were either from the formal mental health system or from community organizations. Stakeholders report that the services to which they transitioned

participants, however well intentioned, were sometimes overwhelmed by the large numbers of new clients they had to absorb on such a short notice, as well as the difficulties and challenges that some participants presented. Indeed, a lot of services were not organized to send case managers out in the community or to help people with complex and multiple issues such as a combination of severe mental illness, substance abuse and personality disorders. Some could simply not afford to provide participants with the same intensity of services as in AHCS, resulting in participants losing their apartments, as in this example reported by this stakeholder:

> "Bien écoute, je pense juste à M... Tu sais, ça nous a fendu le coeur, ça, tu sais, quand y a perdu son logement, parce que l'équipe c'était trop... c'était trop exigeant pour eux, y nous le disaient. [...] Il faisait de l'accumulation, d'abord, y amenait plein de sacs de poubelle, et tout ça. Donc, c'est de l'accumulation dans son logement. Donc, c'est beaucoup de... c'est beaucoup de présences, ça, c'est, tu sais, c'est... c'est exigeant [...] Il était dans l'équipe ACT, si je me souviens bien. Donc, tu sais, c'était une visite par jour avec lui [...] Donc c'est compliqué pour ces équipes là, c'était beaucoup trop ils le disaient, on n'est plus capables. C'est trop exigeant."
>
> *(Well listen, I'm just thinking about M…You know, it broke our heart, you know, when he lost his apartment because it was too…demanding for the team, they told us that. [...] He was hoarding, to begin with, he brought lots of garbage bags, and all that. Thus, it's accumulation in his apartment. So, that leads to lots of visits, you know, it's… it's demanding [...] He was in the ACT team, as I recall. So, you know, it was one visit per day with him [...] So it's complicated for those teams, it was way too much they were saying, we can't do it. It's too demanding.)*

Stakeholders also mentioned that many participants transitioned to usual services would quickly get discharged when they missed three or four appointments, being labeled as "unmotivated and uncooperative". They could regain access to services through the regular path in the system, by requesting services and being placed on a waiting list. Participants transitioned to the formal mental health system were also in many instances diagnosed with only, or mainly, a personality disorder or a substance abuse disorder (even though they may well have also had an Axis 1 disorder at the time of recruitment into AHCS), which rendered them ineligible to receive services reserved for persons who have solely or primarily a DSM-IV Axis 1 mental health disorder. The mandates of some organizations, both in the formal mental health system or in the community were also very narrow. They would never deal with housing-related issues and would for example, not inform the transitional housing team when a participant had not paid his rent or would not help participants to get rehoused if they lost their apartment. Stakeholders believe that several dozen participants lost their permanent housing during the transition, mostly participants who had been served by the ACT team. Some stakeholders offered the interpretation that transitioned participants who remained housed were more advanced in

their recovery and thus required less intensive services and were consequently less affected by the transition:

> "Puis ceux qui sont restés en logement, c'est ceux qui sont, je dirais, euh... d'après moi, c'est dans l'équipe qui ont des besoins modérés et vont beaucoup mieux. Ou qui ont une résilience. Ou qui ont un réseau. Qui sont capables de s'en sortir. Mais, euh... les plus malades, les plus vulnérables, ils ont perdu leur logement, c'est sûr. À peu près sûr. En tout cas, une grande partie."
>
> *(As for those who had remained housed, those are the ones who, I would say, … are those assigned to the moderate needs team and are doing much better. Or who have more resiliency. Or who have a network. Who are able to get out of it. But,… the sickest, the most vulnerable, they've lost their housing, that's certain. Just about certain. In any case, a large proportion.)*

The strategy deployed by the *Agence* to keep everyone housed and attached to services led to some mixed results. In many instances, participants lost their clinical services and subsequently their apartment (or in reverse order). In some cases, participants were transferred to highly motivated and creative teams interested in learning from the AHCS experience and applying the project's core principles, who would continue providing services regardless of the conditions even if the participants lost their housing. Some participants were transferred to newly created ACT teams in CSSSs on the island of Montreal; unfortunately, those teams were only able to add a limited number of persons on their caseload. Stakeholders who supervised the transition reported that those teams were better suited to deal with former AHCS participants, were showing a greater degree of flexibility and that outcomes were generally more positive.

Housing team - managing a long transition. The initial plan of the *Agence* was to transition all participants to usual services and to terminate rent supplements as soon as possible. That would entail finding new housing accommodations for participants who could not afford their AHCS apartment without a rent supplement. During the transition, the *Agence* was providing participants with rent supplements to make sure that none of them would become homeless in the process. It was in fact managing and distributing funds it had received from the federal government to cover funding supplements over a one-year period after the end of AHCS.

In December 2013, despite the transitioning efforts, 131 participants were still housed in an AHCS apartment, a number still far from the *Agence*'s objective. In parallel with the transition and since the end of the AHCS project, stakeholders had been negotiating with the OMHM to obtain rent supplements. The OMHM did agree to provide all participants still housed in December 2013 with emergency rent supplements until 2019, funded through a preexisting program intended for tenants

experiencing financial difficulties and at risk of losing their apartment. They even bent some of their own rules, agreeing to give rent supplements to participants who had accumulated debts with them previously.

The OMHM funded emergency rent supplements to all participants still housed under the sole condition that the *Agence* provide them with an organization acting as an interlocutor between participants, clinical staff and landlords, that they could lean on if problems or crises arose, and that would ensure that participants continued receiving clinical services. The Douglas Institute Housing team played that role for more than a year and a half after the closure of AHCS, until November 30 2014. During that period, the team continued dealing with housing related issues, such as supporting clinical staff when there was a crisis related to mental health, substance abuse, default on rent payment, troublesome squatters, etc., that interfered with the participants' residential stability. It renegotiated contracts with landlords, since the subsidy would be provided by the OMHM with its own specific set of rules. It must be noted that the contracts between AHCS and the landlords had been conceived by the same lawyer who wrote those of the OMHM. AHCS stakeholders had planned since the beginning of the project for contracts to be very similar, in anticipation of a scenario where the government would discontinue the project and participants would need to apply for rent supplements.

The housing team was also given the mission of recruiting new landlords and securing new apartments to move participants, as some landlords preferred not to remain involved after the closure of AHCS. It also oversaw the repairs that some units required when the participants moved out. The scope of the post-AHCS housing team’s mission was broadened; after the end of AHCS, they connected participants to clinical services if they were discharged and still needed to receive support and would sometimes advocate on behalf of participants when those teams were thinking of discharging them because they were missing their appointments, appeared unmotivated or were experiencing issues that were deemed to be unsolvable or too complex.

For administrative reasons that were not officially disclosed, the *Agence* disbanded the Douglas Institute-based housing team in November 2014 and created a new team at the CSSS Jeanne-Mance, that would act as the new interface between the OMHM, participants, landlords and clinical services. The new housing team, named "Équipe liaison logement” ("Housing linking team"), had two FTEs and focused on issues between landlords, clinical services, the OMHM and participants. It took on its caseload 115 former AHCS participants housed with 45 different landlords. The role of this team was more limited than that of the Douglas Institute-based team, in the sense that they didn't have the mandate to rehouse participants or recruit new landlords; they were devoted only to keeping current participants stably housed in their current apartments. This housing team was essential to the

participant's housing stability and it made stakeholders realize that it is not common practice most of the usual services, to which some participants were transferred, to deal with housing-related issues. Indeed, many organizations offer services targeted towards one very specific issue (e.g. substance abuse, specific mental health issue, etc.) but they prefer to avoid dealing with anything that would go beyond their mandate. As such, they generally avoid getting involved in problems or issues pertaining to housing.

The OMHM rent supplement does not "follow" the participant when he moves or is evicted; as a general rule, if a former AHCS participant moves to another non-subsidized private market apartment, they stop receiving their rent supplement, unless the OMHM considers the move to be justified by a serious and immediate hazard to their health (e.g. mildew, important water infiltration, etc.). Therefore, rent supplements given by the OMHM do not fit with HF principles or practice. As noted earlier, they were intended to extend the supply of affordable housing, not ensure that specific individuals be able to maintain affordable housing.

Sustainability Outcomes

Funding/Budget

The initial goal of the *Agence* and probably also of the MSSS, was to completely abolish funding of anything related to AHCS. Things have not quite turned out that way. Diogène managed, not without difficulty and intense rounds of negotiation, to keep a team fully funded for an indefinite duration. Stakeholders, however, have not reported any signs that the government was planning on implementing another HF team in the formal mental health sector in the near future. Although the *Plan d'action interministériel en itinérance 2015 – 2020* makes explicit mention of Housing First teams as being desirable, funding from HPS appeared to be the only potential source of new funding for HF teams in Québec, apart from Diogène, the Équipe liaison logement and the associated rent supplements (PSLs).

Staff retention

As previously noted, the fates of the different teams that participated in the AHCS project are strikingly different. Diogène's team, a year after the AHCS closure, remained identical to what it had been at the project's inception in 2009, with the same five case managers, team supervisor, and organization director.

In contrast, the CSSS Jeanne-Mance ICM and ACT teams were completely disbanded. Some case managers and senior managers moved to newly-formed ACT teams in Montreal or took other positions in the formal mental health system or in various community organizations. Moreover, many high level senior managers in the CSSS Jeanne-Mance, who had given their approval to the AHCS project and were supportive of it and advocated for it, were transferred or retired in the wake of Bill 10. This made it more difficult for stakeholders who were still operating in the formal mental health system to promote HF or practices derived from it.

Consistency of practice of the HF model

Diogène Un Toit d'abord. Diogène's objective is to maintain in their totality the components of the model: the technical elements as well as the philosophy of practice. Diogène's stakeholders expressed the view that their success and the results they obtained, were largely attributable to fully integrating all aspects of HF to their practice. Their objective was to maintain this in the future, including after

receiving HPS funding. Being the only team in Quebec that was part of AHCS and that was still in operation, they felt they had the responsibility to stay and continue providing HF to show that when the model is well applied, it yields good outcomes. Its hope was that doing so would encourage new HF programs to adhere more closely to the model.

The new housing team: the équipe liaison-logement. Following the closure of AHCS, the *Agence* position was ambiguous; it stated publicly that its objective was to not let anyone back into the streets and to continue supporting them, while it was closing the services that helped participants to remain housed. The large numbers of participants rapidly losing their housing pushed them to review their strategy. They allowed the housing team to remain in operation longer than they had initially planned. In addition to Diogène's program, another part of the model was still being kept alive in Montreal after the closure of AHCS;: the staff of the housing team continued to apply the HF model philosophy and relocated many participants into scattered-site apartments with newly recruited landlords. The new housing team, that replaced its AHCS-era counterpart, tried to follow as many elements of the model as possible, while relying on the practical know-how developed by its predecessor. It operated, however, in an organization and a context that allowed it less flexibility than was the case for the AHCS housing team. These factors tended to limit their ability to help participants move when things simply went awry or became intolerable for reasons that were not immediately life-threatening – any number of factors related to the neighbourhood, immediate neighbours or the unit. The Équipe liaison-logement advocated with the OMHM for more flexibility in this regard.

Local-level partnerships

The majority of landlords remained on board and continued housing participants after the closure of AHCS. Some preferred to end their participation, for various reasons. The Douglas Institute recruited more than ten new landlords during the transition to replace those who had withdrawn their collaboration when it was announced that the OMHM would be in charge of the rent subsidies. When the former housing team passed the torch to the new team, 45 landlords (out of 73 recruited during the AHCS project) were still housing participants across Montreal. The new housing team, despite some challenges, has continued its collaboration with all the landlords. It pays special attention to maintaining good relations with landlords and preserving a strong partnership.

Diogène has continued to build relationships with many actors and organizations in the community. They report working closely with psychiatrists in the formal mental health system and helping the participants attend their appointments on a regular basis. This is especially critical for their

organization, as they do not have, as do ICM teams in the formal mental health system, an easy access to such resources. This partnership creates a virtuous cycle; participants miss fewer appointments and the psychiatrists tend to get more involved in the therapy. Stakeholders report that it is not uncommon for psychiatrists to get disillusioned and a little bit cynical about the positive impact they can have on the lives of persons with complex issues who frequently miss their appointments, other than stabilizing them for a short period of time when they get hospitalized.

With the potential HPS funding, Diogène hopes to be able to shift gears and house 100 new clients. They are planning on recruiting those via referrals from various organizations, either in the formal mental health system or among community organizations, and have developed formal partnerships with them. The bulk of the new participants (40) would be referred by PRISM, an innovative partnership between one of Montreal's largest shelters, the Old Brewery Mission, and one of Montreal's major university hospitals, the CHUM. The rest of the participants would come from another program of the CHUM for young people experiencing a first episode of psychosis; from one of the largest psychiatric hospitals in Montreal, the Institut universitaire en santé mentale de Montréal (IUSMM); and from two women's shelters that both collaborated with AHCS: Le Chaînon and La Maison Marguerite. Diogène stakeholders indicate that they will pay specific attention to selecting participants that can be served by an ICM (and not by an ACT team), but will make sure that they get referred people who can benefit from their program and not only the organizations' "favourite clients."

According to stakeholders, the OMHM has been an essential and very collaborative partner. They have a very good understanding of the situation and issues that can arise, and throughout the transition, tried to put as few barriers as possible to the provision of rent supplements.

Routinization of Housing First

With the *Agence* guaranteeing the permanent funding of their ICM team, Diogène Un Toit d'abord is now focusing its attention on increasing its size in preparation for obtaining HPS funding. Diogène mastered the HF model a few years ago, a fact illustrated by their high fidelity scores during the AHCS project. They continued honing their skills during and after the AHCS project. The fact that they managed to retain all their original staff and are openly committed to champion HF is a good indication that this model has become well implemented in this organization. In addition, as reported below, their fidelity scores have remained high. Diogène Un Toit d'abord stakeholders clearly state that their objective is to remain committed to the HF model. When the interviews were conducted in May-June 2015, Diogène was the only organization in Quebec for whom HF was more a routine than a novelty.

Influence of the HF Model on Practice in Mental Health, Addictions and Housing Systems

The AHCS project had multiple impacts and influences on various organizations, especially in Montreal. Teams were created by formal mental health institutions in partnership with community organizations, which were directly inspired by the AHCS experience. Intervention methods developed during this project have been documented and are now publicized and case managers or managers returning to their organization are bringing back some knowledge and practices that were developed during AHCS.

The SII – A team inspired by the AHCS experience. In partnership with the Old Brewery Mission, the CHUM has created the Suivi Intensif en Itinérance (SII) team. It has been implemented under the leadership of stakeholders who were involved in AHCS. The objective of the team is to help persons who are homeless and who are experiencing psychotic disorders to obtain residential stability, either in scattered-site or congregate apartments. At the time when this report was written, the goal was to serve 40 clients, for a maximum period of 18 to 36 months. Four case managers from the former AHCS clinical teams have become integrated with the SII. This team does not systematically have access to rent supplements, but this is, according to some stakeholders, the only noticeable difference:

> "Évidemment, y a pas les PSL… ne sont pas systématiques ici, on en a quelques-uns à notre disposition, mais sont pas systématiques. Mais c'est le même travail, de trouver un logement, puis aider la personne à s'établir dans son logement, dans la communauté. Donc, on peut dire que ça, c'est similaire [...] La philosophie est restée la même au niveau de… Bien, moi, je pense que la philosophie de base, c'est de… pas que ce soit étapiste, hein, que, OK, c'est bien, si tu veux un logement, y faut d'abord que t'ailles, exemple, en logement supervisé, puis on verra après. [...] On y va selon le besoin, évidemment, on fait place au rétablissement en santé mentale. [...] Fait que déjà, y a ça, donc, la personne est logée sans condition, fait que c'est comme le projet Chez Soi, la… la philosophie, si tu veux, du Logement D'Abord."
>
> *(Of course, it's missing the rent supplements…they are not systematic here, we have a few at our disposal, but they are not systematic. But it's the same job, to find an apartment, then to help the person to get established in their apartment, in the community. So, we can say that, that is similar [...] The philosophy has stayed the same in terms of… Well, as for myself, I think that the basic philosophy, it's… not to be step-wise, eh, that, OK, that's good, if you want an apartment, you need, first to go, say, in supervised housing, and we'll see afterwards. [...] We go according to need, of course, we try to go along with recovery in mental health. [...] So already, there is that, the person is housed without conditions, so that's like the Chez Soi project …the philosophy, if you like, of Housing First.)*

Officially, this team is not applying HF and has not received training from the MHCC, but according to stakeholders, the philosophy of practice is greatly inspired by AHCS. (It may be noted, however, that the time-limited nature of the service constitutes another difference from the HF model.)

Knowledge transfer from AHCS. A few AHCS stakeholders report having been invited by senior managers in the formal mental health system to give a presentation to ACT or ICM teams. They were not invited to give a presentation that directly addresses HF, but to discuss other related approaches, or philosophies of practice, such as recovery, in the context of their experience within AHCS. These are occasions for the stakeholders to indirectly present HF in a context where the political aspects of the model are not at the forefront. Their general impression is that HF is of great interest to the case managers and front-line workers, often more than to people who are higher in the hierarchy, who generally are less familiar with what is happening on the ground.

Even if the AHCS teams were evolving within a specific set of constraints provided by the HF model, they also had an excellent opportunity to test and develop innovative and concrete practices in a hands-on environment. Project management was flexible, encouraging staff to be creative and to test new approaches while meeting HF goals and respecting its core principles. The practices that were developed and that emerged in this context were documented during the project, thanks to a project for which Chez Soi co-investigator Roch Hurtubise obtained separate funding and are presented on the the CREMIS' website. These "practice stories" (récits de pratiques) are used to inform other actors who offer services to homeless people, either in the formal health system or in community organizations. These "practice stories" really sparked interest and stakeholders report being frequently asked to present them to groups or organizations who want to adopt them. According to one stakeholder, this report won the 2014 prize for the best innovative practices developed in the Quebec health and social services network.

A presentation of these practice stories in a formal mental health organization has attracted an unusually large audience:

> "Y avait facilement 80 personnes, la salle était bondée, tout le monde était debout en arrière, on n'avait jamais vu ça, là. Y avait vraiment, tu sais, des gens qui voulaient savoir (ton enjoué) qu'est-ce qui s'était fait".
>
> *("There were easily 80 people, the room was full, everybody was standing in the back, we'd never seen that. There were really, you know, people who wanted to know (playful tone) what had been done.")*

A researcher affiliated to AHCS also presented these stories in France, to teams applying HF as part of a large scale pilot project akin to AHCS, "Un chez soi d'abord".

According to stakeholders, AHCS also provided an occasion to confirm the effectiveness of several practices, such as delivering services in the community or adopting a recovery orientation when working with people with dual diagnoses (mental health and substance abuse). Such people are often ignored or underserved by the system. Other stakeholders, who have a certain level of influence within the organization they are now working with, report that the project had an influence on their current practices:

> "Oui, bien, ç'a changé… je te dirais que quand les gens sont… sont plus malades, tu sais, qu'y ont… tu sens qu'y sont… sont plus délirants, plus psychotiques, je suis moins… je prends plus mon temps, je suis beaucoup plus dans l'écoute de ce qu'y veulent, puis de prendre le chemin qu'eux autres veulent prendre, je suis moins dans, « ah, moi, je le sais qu'est-ce que ça y prend [...]"
>
> *("Yes, well, things have changed… I would say that when people …are sicker, you know, that they have…that they are more out of touch with reality, more psychotic, I am more…I take more time, I am much more oriented towards listening to what they want, and to take the path that they want to take, I am less into, "well, I know what it is that s/he needs […]")*

Policy and expansion/dissemination of HF model. Despite initial opposition towards the At Home/Chez Soi project, the Government of Quebec ultimately endorsed the HF model in its *Plan d'action interministériel en itinérance 2015-2020*, it identified the model (referred to in that document as "Logement d'abord", a literal translation of Housing First) as one of the approaches that should be applied to help people exit homelessness. Provincial funding for programs of this type remained, however, very limited – essentially some support to Diogène's Un toit d'abord program. The government did accept that HPS fund Housing First programs in the province, under a new name, "stabilité résidentielle avec accompagnment" (SRA[8]), which can be translated as "residential stability with support."

Some stakeholders point out that the French government's decision to fund a HF pilot project ("Un chez soi d'abord") was partly influenced by the fact such a project was already taking place in Quebec! Indeed, France's project began just a little later and stakeholders from France had developed a partnership with several people involved AHCS in Quebec, greatly facilitated by the cultural and language proximity. During all of AHCS, visits, knowledge exchange and research discussions were fairly frequent between France's and Quebec's researchers, key senior managers, case managers and peer support workers.

[8] Even if the SRA is the new designation for HF in Quebec, we will use "HF" in the rest of the document for the sake of consistency. Excerpts from stakeholders might refer to this designation, but we will consider SRA and HF as interchangeable.

Stakeholders note that many organizations were interested in applying HF in Quebec, with requests for more than double the available amount of funding from HPS for the period 2015 – 2019 (about $20 million).

Among the organizations that expressed a significant interest, the three largest and best-known shelters of Montreal, together with another large organization providing both a large day centre and supportive housing (Accueil Bonneau), formed a consortium to ask for HPS funding. Their goal was to share housing supplements and a housing team, while they would each have their own clinical team. Stakeholders noted that not only were many organizations interested in obtaining HPS funding, but that their mentality and philosophy are also evolving. This could be considered as a legacy of AHCS:

> "On sent de plus en plus la… la capacité, aussi, le vouloir des organismes de changer leurs façons de faire. On le sent. Y veulent des suppléments au loyer, y veulent que la personne choisisse son lieu. Ça, c'est nouveau. Ça, c'est le Projet Chez Soi qui a amené ça."
>
> *("One senses more and more … the capacity, also, the desire of organizations to change their ways of doing things. You can feel it. They want rent supplements, they want people to be able to choose where they are going to live. That, that's new. That, that's a contribution of the Chez soi project.")*

Program fidelity and adaptations

One of the only adaptations to the original model that Diogène plans on making is to integrate housing team workers into their organization, together with the clinical team. The objective is to have them working together more closely and to include them into the weekly meetings. The presence of both groups at the same table should facilitate discussion to solve housing-related issues. Indeed, case managers are often very well aware of their clients' difficulties and challenges and it is not infrequent that they can feel or predict when they might experience a relapse or some setbacks. At the same time, housing team workers will often have specific information regarding housing issues and the relationship with a landlord. Including the housing team workers in weekly meetings could help prevent crises, as opposed to being forced to react to them. As one stakeholder states:

> "Donc, y a une situation avec untel, y a une situation où l'intervenant va aborder ce qui est fait. Ah, y a eu une plainte de propreté. OK, mais où est l'intervenant… Oui, mais le propriétaire n'a pas été charger son loyer de… ça va être discuté là. En même temps, l'agent logement va pouvoir comprendre… entendre qu'est-ce que l'intervenant est en train de travailler actuellement. Souvent, nous, on a… on… on arrive à prévoir ce qui s'en vient. Fait que, dans nos réunions, on dit, OK, on s'en va vers ça, on a vu ça, OK, y a une détérioration, donc… Mais là, l'équipe Logement ne l'apprendra pas après ou durant."

("So, there's a situation with so-and-so, there's a situation where the case manager wants to address what's being done. Ah, there's been a complaint related to cleanliness. OK, but where is the case manager? Yes, but the landlord has not charged his rent of…that's going to be discussed then and there. At the same time, the housing team worker will be able to understand…hear what the case manager is working on at the moment. Often, we…we're able to know what's coming down the road. So that, in our meetings, we say, OK, that's where we're headed, we've seen that, OK, there's a deterioration, so…But now, the housing team won't learn about it after or while it's happening.")

Detailed results of Diogène ICM team's self-scored fidelity assessments are presented in the Appendix. Diogène reaches the highest fidelity score possible (4 out of 4) on almost all of the domains of the scale: housing process and structure, separation of housing and services, service philosophy, and team structure/human resources. The one exception is service array (average score of 3.51). Items where highest fidelity has not been met are: the way treatment goals are set (3.6 out of 4), substance use treatment (2.5) and physical health (1.6). To obtain the highest fidelity score in the way treatment goals are set, Diogène should identify barriers to achieving goals. For the substance use item, to attain highest fidelity, Diogène should conduct systematic and integrated screening and assessment and use approaches such as CBT, relapse prevention, or other EBP or Promising Practice (e.g. BRITE). As for the physical item, to obtain a perfect score, the team would need to offer services related to screening for medical problems or medication side effects, managing medication related to physical health, conduct health promotion, prevention and education activities and provide on-site diagnosis and treatment of physical health conditions.

Other Outcomes

Peer support workers' experience. AHCS provided an occasion to deepen the understanding of the potential contribution of peer support workers. This subject has been studied by the CREMIS and has been the object of many publications and conferences as well as a Ph.D. thesis (Godrie, 2015). (The project also provided an opportunity for many peer support workers to participate in research events and knowledge exchange activities in France and Belgium.) They could learn from their peers in Europe and transfer the knowledge they had acquired in Canada[9]. According to stakeholders, the peers clearly contributed to improve practices, in a way that was documented:

[9] The *Un Chez Soi d'abord* project in France, whose clinical leader (Dr Vincent Girard) maintains close links with Dr Larry Davidson and other recovery specialists at Yale, includes peer specialists.

> "Et c'est une retombée directe du projet, à tous les niveaux, au niveau scientifique. Et puis, euh… Donc, toute cette expérience des… des pairs, dans le projet, des pairs aidants, puis l'ouverture des équipes, et l'ouverture de la psychiatre qui était principalement présente, qu'est-ce qu'elle dit dans ces entrevues, de comment elle a repensé sa manière de penser un diagnostic, et tu vois. Euh, là, elle dit que, à partir des expériences du travail avec les pairs, elle parle plus de diagnostic en psychiatrie, mais de perspective diagnostique, c'est quand même assez intéressant."
>
> *("And that was a direct benefit from the project, at all levels, at the scientific level. And also, hmm…So, this whole experience … of peers, in the project, of peer support workers, and the openness of the team, and the openness of the psychiatrist who was the most present, what she said is these interviews, how she rethought her way of thinking about a diagnosis, and you see. So, there, she says that, based on experiences of working with peers, she no longer talks about diagnoses in psychiatry, but of diagnostic perspectives, that really is pretty interesting.")*

One of the results of AHCS has thus been to further promote the role and importance of peer support workers in the formal mental health system. Peer support workers from AHCS have taken permanent positions in the formal mental health system and one has been given the mandate to create teams of peer support workers at the CHUM, based on their experience with AHCS.

Creation of the MMFIM. The provincial government's decision to gradually discontinue funding for AHCS services in 2013, led some stakeholders to the conclusion that there was a need in Montreal for leadership to tackle homelessness with a view to ending it rather than allowing it to be maintained indefinitely. No advocacy group or politician was advocating for the project or the model, even remotely. Moreover, at the time, negotiations between the provincial and federal governments concerning the federal government's intention of re-orienting about two-thirds of HPS funding towards Housing First programs, which could have allowed a continuation of the existing programs, had still not been concluded. In March 2013, the situation seemed desperate; the project was being terminated, and the participants transitioned to usual services and funds to do otherwise were not available. The relative indifference in which the project was ending shocked many stakeholders, who saw the need for a group that would exert stronger leadership, in the direction of planning to end homelessness, in Montreal. Concerned stakeholders founded a group dedicated to finding and promoting solutions to end homelessness in Montreal, over a relatively short time-span; the Mouvement pour mettre fin à l'itinérance à Montréal (MMFIM) was born in the months that followed the end of AHCS.

The MMFIM is composed of key persons from a wide and diverse variety of organizations in Montreal: not-for-profits working with homeless people, shelters, members of the business community, public

institutions and agencies as well as researchers. The goal is to influence policy makers, politicians and officials at all levels of the municipal administration, provincial and federal government, as well as donors and institutions of civil society.

At the moment of writing this report, the MMFIM has already had a considerable impact on Montreal's homelessness policies. First of all, it successfully advocated for the City of Montreal to carry out a point-in-time count, which was led by the MMFIM and carried out by a consortium led by the Douglas Hospital Research Centre and including several other organizations. It advocated to hold in Montreal the 2015 conference of the Canadian Alliance to End Homelessness and contributed with the City of Montreal to organize the event, during which HF was discussed. Even the RAPSIM's leadership conceded that this model has its place (albeit a limited one). Finally, in December 2015, the MMFIM has presented a plan to end homelessness in Montreal, which was generally well received in the media. The plan identified HF as a key approach to address chronic and episodic homelessness.

Factors Influencing Sustainability

Ongoing Training and Feedback

Stakeholders generally express concerns regarding ongoing training and feedback. In their view, the fact that adequate training and feedback are difficult to obtain constitutes an obstacle to HF sustainability in Quebec. The MSSS has not allowed the MHCC per se to provide training in the province. It asserts that all the necessary expertise and knowledge to give HF training exists in Québec. Several stakeholders, however, doubt that this is the case. The fact that French training material is not readily available is also identified as an obstacle:

> "J'ai du matériel de formation qui est tout en anglais, la Commission m'a rien donné en français encore, que je suis en train de commencer à mettre en français pour que, si jamais y a des demandes de formations, que je sois prête, puis que je sois pas… pas prête à dernière la minute. Mais j'ai vraiment l'impression d'être toute seule avec mon matériel dans une Province où pffff…"
>
> *("I have training materials that are in English, the Commission has not yet given me anything in French, I am starting to translate some of them into French so that, if ever there are requests for training, I can be ready, so I can avoid…being ready at the last minute. But I really have the impression of being alone with my material in a province where pfff…")*

After the end of AHCS, a researcher affiliated with the project held meetings with several community organizations that would be applying for HPS funding to plan for HF training that would involve experts, including one of the model's founders, Sam Tsemberis. The organizations however needed authorization from the MSSS to receive this training and after a few meetings, they declined the offer and indicated that they were finally not interested in this proposal. At the time interviews were conducted, only two smaller community organizations had benefited from more in-depth training from Diogène or other stakeholders[10].

Stakeholders associated with AHCS mention being frequently contacted by numerous community organizations (including in other parts of Québec) to obtain additional information. In some cases, the information requested is only very specific tools and information, such as the formal agreement that was used between the housing team and landlords, unit repair policies, the appropriate rate of intake of clients, etc. Stakeholders emphasize that these are only small technical components of HF, which are not very useful if the model is not applied as a whole, especially without its core philosophy and principles. In other cases, requests are from organizations around the province, that are at a loss as to how to implement the model and don't know who to ask to receive training and information. Lack of leadership in facilitating implementation of the model will, according to one stakeholder, impair Montreal's capacity to provide housing to persons who are homeless:

> "Et j'ai beaucoup d'appels. Beaucoup d'appels d'organismes, euh, qui cherchent à… à comprendre, à implanter le modèle, et y savent pas comment faire. Puis y a… y a un vide. Donc, étant donné qu'y a pas de leadership ici, là, nulle part, bien moi, je pense que les gens vont rester encore dans la rue très longtemps."
>
> *("And I get a lot of calls. A lot of calls from organizations who, eh, who are trying …to understand, to implement the model, and they don't know how to do it. So there's a..there's a vacuum. So, since there's no leadership here, there, anywhere, well I, I think that people are going to remain the streets for a very long time.")*

Local Leadership

The majority of stakeholders identified RAPSIM as the standard bearer that systematically advocated against AHCS and HF over the media, internet, in public events, in research events and in the bulletins and reports that they publish on a regular basis. Stakeholders report that RAPSIM would frequently

[10] Since that time, we have learned that another stakeholder, with MHCC training, has provided some training to HPS-funded HF programs managed by the large shelters.

send members or representatives to scientific conferences where AHCS representatives were speaking, to speak against HF and AHCS. This organization also lobbied the government or other influential organizations, such as the SHQ, against AHCS. Stakeholders noted that RAPSIM has decades of experience in their domain, are well known and respected, are extremely well organized, and have substantial connections in various fields, such as politics, community organizations and with other advocacy and lobbying groups. They are generally abundantly cited in francophone media. Almost every time HF, AHCS, HPS reorientation or any other homelessness related issue is discussed in the French-language media, the RAPSIM is invited to give its comments and opinions. They consequently have an abundance of channels to relay and convey their messages and official positions. Stakeholders believe that RAPSIM might have had a decisive impact on the fate of AHCS in Quebec. Indeed, many of them mentioned that before AHCS, they would often give serious consideration to RAPSIM's official positions about public policies and that this is often the case for people working in community organizations and the formal mental health system:

> "Moi, perso, là, y a des dossiers que je connais assez peu, puis pour lesquels je m'appuyais sur le… la posture du RAPSIM, par exemple, pour savoir… ou du FRAPRU ou… puis c'est ça, c'est des interlocuteurs qui… quand qu'y prennent la place… la… la parole sur la place publique, y a plusieurs gestionnaires, superviseurs cliniques, tout ça, qui sont restés un peu là-dessus, aussi, parce qu'on pense, a priori, que c'est des gens qui sont plutôt… des groupes qui sont plutôt pour les personnes à la rue, dans la défense de droits des personnes […]"
>
> *("As for me, there are some issues that I don't know well, and for which I relied on the…on RAPSIM's position, for example, to know…or the FRAPRU[11] or…so that's it, it's groups who…when they express themselves…in the public square, there are several managers, clinical supervisors, all of those kinds of people, who kind of based themselves on that, also, because we think, a priori, that these are people who are rather…groups who are rather oriented towards promoting the interests of street-involved people, towards defending peoples' rights […]")*

Most stakeholders believe that RAPSIM presented a narrow and incomplete vision of HF and AHCS. It misinformed its members, community organizations staff and the general public. This situation became even more obvious when a Belgian delegation visited Montreal and met with key stakeholders from AHCS Montreal as part of a knowledge exchange activity, which occurred after the official end of AHCS. The delegation was composed of 15 Belgian government representatives and community organizations leaders that were implementing HF in Belgium. While they were in Montreal, they visited many community organizations and a conference was held to present the main AHCS results. Various

[11] *FRAPRU: Front d'action populaire en réaménagement urbain* (Populist action front for urban redesign).

community organization representatives in Montreal were invited and were astonished to hear that AHCS was not what they had been led to believe, as reported by this stakeholder:

> "[…] j'ai fait une présentation, y en a d'autres qui en ont fait, puis y a des gens du communautaire qui ont été invités, et j'ai entendu des commentaires du genre, "ah, oui?! C'est pas comme ça qu'on m'avait présenté ça, c'est pas ce que je pensais, je suis vraiment impressionnée, si j'avais su." Fait que c'est comme, je… je trouve que le RAPSIM a informé partiellement les groupes, avec leur vision de ce qu'était le projet Chez Soi et y ont grandement influencé toute la… l'espèce de propagande qui s'est faite contre le projet. Moi, je pense que le RAPSIM a eu un gros poids au niveau politique, aussi. Fait que c'est sûr que ça m'a vraiment déçue par rapport à eux. Je pense qu'y ont eu… y ont eu une influence sur ce qui s'est passé."
>
> *(" […] I made a presentation, other people made some too, and then there were people from community organizations who were invited, and I heard comments like, "oh, really?! That's not how it had been described to me, it's not what I thought, I'm really impressed, if I had known." So that it's like, …I think that RAPSIM informed groups only in part, out of their vision of what the Chez Soi project was and they greatly influenced all that…the kind of propaganda that was made against the project. Personally, I think that the RAPSIM carried a big weight at the political level, as well. So for sure this really disappointed me about them. I think that they had…they had an influence on what happened.")*

Resistance to AHCS also came from the *Agence*; it was far from being supportive of the project and stakeholders mention that they had many difficult meetings with representatives of this organization and that it sometimes appeared like they were only trying to hinder the project.

Some stakeholders report that they were told by representatives from the *Agence* that the transition made them realize that many services in the formal mental health system were simply not equipped to deal with people with complex issues. In other words, the *Agence* realized that some service providers were not doing their job the way they thought they were. According to stakeholders, this seemed to increase the resistance they perceived from the *Agence*. The *Agence* also expressed skepticism concerning the research findings. Furthermore, stakeholders mention that there appeared to have been no counter powers strong enough to oppose RAPSIM or the *Agence*.

Community Context

The Montreal AHCS project met from the start with significant opposition from community organizations and groups at one level and from the provincial government at another level. The arguments that were then invoked against the project – the provision of public funds to private landlords via rent supplements, the implicit devaluing of existing and well-established programs and the perception that HF aimed to displace them all, the encroachment by the federal government into an area of provincial jurisdiction – all continued to fuel opposition to the model after the end of the project. This continued even as the positive results of the intervention were becoming increasingly well documented by quantitative and qualitative research, as well as by public testimonies of AHCS participants and staff. HF and the AHCS project were often viewed as two sides of the same coin by many community organizations, who perceived the model as a serious threat to their services and their funding and even to the long-term sustainability of social housing. The federal reorientation of Homelessness Partnering Secretariat (HPS) funding towards HF in the months that followed the end of AHCS seemed to justify these apprehensions and exacerbated resentment towards the model and the project, which was now associated with the reorientation and perceived by some as directly responsible for it. This view is even stronger in regions outside Montreal, where HF and AHCS are less known and understood. The reorientation of HPS funding towards HF had dramatic potential consequences for some organizations that were significantly dependent on this source of revenue, especially those offering transitional housing. Those organizations dedicate a lot of their funding to their buildings and the services they offer do not meet HF criteria and are thus ineligible for the portion of HPS funding (about two thirds) that had been reallocated to support HF.

Community organizations and institutions philosophy of practice. The philosophy of practice of community organizations and the formal mental health system was pointed out by many stakeholders as one of the obstacles to the dissemination of HF. The Continuum of Care (CoC) approach is deeply entrenched in the practices and philosophy of the vast majority of organizations in the province of Quebec[12]. Many had never heard about HF before and were intuitively opposed to it. Switching from the CoC approach to HF is a leap still difficult to make for many organizations. In their view it is irresponsible to give an apartment to a person who is experiencing mental health problems and substance abuse disorders and that they perceive as not stabilized and housing ready. Some

[12] PECH, a large and well-known community organization in Québec City, has, for several years, been offering rent subsidies (PSLs) to give people with severe mental illness access to ordinary apartments with supports. It is not clear to what extent they have also been helping homeless people with mental illness access such apartments directly.

organizations' reluctance about HF is also linked to their concern about housing a person who might generate problems and conflicts with landlords and neighbourhoods and ultimately hurt the organization's reputation and negatively impact their funding. Many community organizations still hold this view, even after the end of AHCS.

The belief that solutions to homelessness are mostly defined in terms of financial resources and not in terms of service structure or philosophy was widespread at the onset of the project. Many of them would argue that they already knew how to reduce homelessness and that they only needed more resources. Accordingly they did not acknowledge the need for a project to test a new approach with public funding that they felt in dire need of:

> "[...] y en a eu pas mal de... de rencontres avec la FOHM, le RAPSIM et tout ça. Mais eux, y disaient, bien non, nous, on fait ça déjà depuis très, très longtemps. [...] Donnez-nous l'argent, puis partez, parce que nous, on le fait déjà. [...] Les gens ne sont pas habitués de travailler avec des chercheurs. Donc, la pertinence d'une recherche, à quoi ça va servir? C'est ça que les gens nous disaient."
>
> *("[...] there've been quite a few…meetings with the FOHM, the RAPSIM and all that. But, they were saying, no, we already have been doing that for a very, very long time. [...] Give us the money, then leave, because we're already doing it. [...] People are not used to working with researchers. So, the relevance of a research project, what will it be used for? That's what people were telling us.")*

Housing participants in scattered-sites apartments owned by private landlords is still an important point of contention among community organizations, especially since funding for social housing was progressively being cut by the federal government. Critics of HF and AHCS argue that the funds spent on rent supplements in the private market leave nothing in the community. In their view, these funds should rather be invested in social housing, viewed as more durable and permanent and part of the collective heritage. Therefore, many organizations feel that they are already following best practices and believe that they are already intervening in a manner similar to HF. The AHCS and HPS reorientation is perceived as an attack on their services.

Overall, stakeholders report that the contexts both in the community organizations and in the formal mental health system were not propitious for system change. Transition of AHCS participants to usual services has demonstrated, in many instances, that the system is not configured to help people with multiple and complex issues. Changing that situation would require a profound transformation in the system's culture and organization. Stakeholders have the impression that with the exception of a few initiatives and programs of the former CSSS Jeanne-Mance, the formal mental health system system

currently has a lot of difficulty dealing and working with people with complex and multiple problems, such as those in the AHCS project:

> "Je sais à quel point c'était difficile dans les hôpitaux psychiatriques, même une personne qui voulait des soins, c'était difficile quasiment, quand t'étais itinérant. C'est comme si la santé mentale aime avoir des patients organisés, qui ont un trouble de santé mentale, mais qui sont pas… Sont fonctionnels, c'est ça qu'y aiment, c'est les beaux petits patients parfaits, ça, pour eux. Alors, quand nous, on arrivait avec une personne en situation d'itinérance, qui a un trouble de santé mentale, dans une urgence psychiatrique, on travaillait fort en maudit pour qu'elle ait des soins. Y… y en voulaient pas. C'est comme des patates chaudes."
>
> *("I know to what extent it was difficult in psychiatric hospitals, even someone who wanted care, it was almost difficult, when you were homeless. It's as if mental health likes having organized patients, who have a mental disorder, but who are not… Are functional, that's what they like, nice little perfect patients, for themselves. So then, when we would arrive with a homeless person, who has a mental disorder, in a psychiatric emergency, we worked very hard so that person could get care. They…did not want them. They were like hot potatoes.")*

Misunderstanding of Housing First. This resistance to HF as well as the lack of space for discussion creates a situation where the core components of the model are not really understood by many actors that stand against the model:

> "[...] c'est clair qu'y a beaucoup de gens qui savent pas vraiment ce que c'est, le Logement d'abord. Périodiquement, on voit des références dans les médias, au fait que y a pas de… de soutien avec le Logement d'abord, que c'est pas une bonne idée de juste mettre les personnes dans un appartement, puis les laisser là. Donc, y a comme une mauvaise compréhension de ce que ça implique."
>
> *("[...] it's clear that there are a lot of people who don't really know what Housing First is. Once in a while, you see references in the media, to the fact that there's no…support with Housing First, that it's not a good idea to just put people in an apartment and then to leave them there. So, there's a lack of understanding of what it implies.")*

Even when key stakeholders of community organizations or of institutions in the formal mental health system have an understanding of the general components of HF, they often understand only partially the model's philosophy or the way it translates into practice, as mentioned by this stakeholder:

> "[...] une directrice de je me souviens pus quel organisme, je pense que c'était [une grosse institution publique], m'a dit, euh : qu'est-ce que vous répondez aux gens qui vous disent que le projet Chez Soi était un… est un modèle de… totalement de prise en charge des personnes, et qu'on laisse peu de place à l'autonomie? Fait que ça, c'était la vision qu'ils avaient, parce que, euh, on avait beaucoup de moyens, parce qu'on… on fournissait le logement avec 25% du revenu, puis qu'on relogeait rapidement, c'est

comme si on donnait tout cru dans le bec à tout le monde, puis qu'on les prenait en charge, puis qu'on limitait leur autonomie. C'était la vision que les gens avaient. Tu vois qu'y avait une incompréhension, totalement, de comment on… on travaillait."

("[...] a director of I forget which organization, I think it was [a large public insitution], told me, hmm: what do you say to people who tell you that the Chez Soi project was a…is a model of…completely taking people in charge, and that little room is left for autonomy? So that, that's the vision that they had, because, hmm, we had a lot of financial resources, because…we were providing housing with 25% of the income, and then rehoused people quickly, it's as if we were doing all the work for people, taking charge of them, limiting their autonomy. That was the vision that people had. You see that there was a lack of understanding, totally, of the way we…we were working.")

HPS reorientation. Stakeholders mentioned that the HPS funding reorientation had both positive and negative impacts. On the positive side, the reorientation is inciting organizations to adopt HF and forcing the model into the public discussion. Very recently, it's starting to make its way into many organizations, even in some that were rather hostile or doubtful when AHCS began. The political issues associated with the model, that had dominated public discussion, are slowly starting to recede and, as stated by this stakeholder, the discussion is beginning to move forward – acknowledging a place, albeit limited, for HF:

"[...] sur les mérites propres de l'approche Housing First. Je ressens vraiment un cheminement des esprits, euh, parce que, mettons, aux État généraux sur l'itinérance cette semaine, [...] il y avait 300 personnes présentes, quasiment de tous les milieux de l'itinérance au Québec. Mais même dans le discours d'ouverture par le président du réseau sur l'itinérance, qui est aussi responsable du RAPSIM par exemple, qui a été historiquement très opposé à… à la venue… même son petit discours, y disait que c'est une approche intéressante, Housing First, mais y a beaucoup de choses qui sont pertinentes. Il y a d'autres choses, il y a d'autres approches. Il faut faut favoriser une diversité d'approches, mais cette approche-là a sa place et c'est bon pour certaines populations."

("[...] on the actual merits of the Housing First approach. I really have the impression that perceptions are changing, hmm, because, for example, in the Estates general on homelessness [13] this week, [...] there were 300 people there, from practically all homelessness sectors in Québec. But even in the opening speech of the director of the homelessness network, who is also responsible for RAPSIM for example, who was historically very opposed to …the coming…even in his little speech, he said that is was an interesting approach, Housing First, but that many things are relevant. There are other things, other approaches. It's necessary to support a diversity of approaches, but that approach has its place and it's good for certain populations.")

[13] An occasional conference to provide an overview of the state of homelessness in Québec, organized mainly by the RAPSIM.

On the negative side, the HPS reorientation crystallized the opposition to the HF model and generated a lot of discontentment and tensions, especially in the regions outside Montreal, where homelessness often takes a different form. Stakeholders point out that we have never really measured the impacts of many programs that have ceased to be funded in the rest of the province, in the wake of the HPS reorientation. This could have dire, unexpected consequences precisely on the individuals that HF is trying to serve, all the while contributing to the discontent around the HPS reorientation.

The federal Conservative government also had a very bad reputation in Quebec, especially among service providers in health and social services programs. Many were very suspicious of the intentions behind the HPS reorientation and were convinced that they were motivated by purely ideological motives:

> "Le gouvernement fédéral, tu vois, qui a très mauvaise réputation chez beaucoup, beaucoup de gens… Par rapport à tout ce qu'y font, si tu veux, sur le plan social, politique, international, écologique, et donc, c'est un gouvernement qui a très, très, très peu de faveur de la population. C'est clair que quand ce gouvernement-là prend position pour quelque chose, tout de suite, ça soulève beaucoup de… de questionnements, de… qu'est-ce qui arrive? Comment ça s'inscrit dans une démarche à droite, si tu veux, idéologiquement très biaisée, ça doit être mauvais, y doit y avoir quelque chose de caché là-dedans. Alors, c'est clair que dans la transformation des politiques de financement, si tu veux, de l'action en itinérance, avec programme SPLI, là, euh… au-delà des mérites, si tu veux, du projet et de l'approche Housing First ou pas, là, il y avait une sorte de méfiance."
>
> *("The federal government, you see, has a very bad reputation with many, many people…Because of all that they're doing, if you like, in social, political, international, ecological areas, and thus, it's a government that has very, very, very little favour with the population. It's clear that when this particular government takes a position in favour of something, right away, that raises many…questions…what's going on? How this fits into a right-wing movement, if you like, very biased ideologically, it must be bad, there must be something hidden there. So, it's clear that in the transformation of these funding policies, if you like, of action in homelessness, with the HPS program, there, hmm…beyond its merits, of the project and of the Housing First approach or not, there, there was a certain wariness.")*

The concrete impacts of the reorientation of HPS on sustainability of HF in Quebec were, at the moment of writing the current report, still unclear and difficult to measure. It might take a few years for the impacts to materialize. And even with the reorientation, stakeholders point out that it concerns, in fact, a very small fraction of the total amount spent on services for homeless people in Quebec. It is far from certain for the moment that the HPS reorientation is enough to support and sustain HF in the long run and to incentivize the provincial government to fund its own programs or to take over funding of new HPS-funded HF programs if, and when, their funding ceases in 2019.

Funding Context

In Quebec, grant applications to obtain HPS funding for HF (SRA in Québec) had to be reviewed and approved by the *Agence* with input from other stakeholders, who submitted them to the federal government. The process of finalizing the budgets of projects, in which the *Agence* played an important role but with a number of constraints from the federal government, appeared to many organizations to not take into account sufficiently the realities of delivering an HF intervention. For example, according to some stakeholders, the *Agence* would not ask for enough money to fund the required clients/case managers ratio for some organizations, while it would ask too much for others; it would not ask for enough to provide participants with insurance; it would force the organization to have a client "recruitment specialist" even if these organizations did not need one. They would also dedicate the same amount of funding for housing teams of all organizations, regardless of the number of participants followed and provide funding for housing teams only in the first two years and none after that. This apparent lack of understanding also raised doubts about how well the federal government would be able to evaluate the programs:

> "Y a… y a un certain contrôle par le gouvernement fédéral, mais je suis un peu sceptique, voyant le manque de compréhension, de… de ce que c'est, Logement d'abord, qui est reflété dans ce qu'y nous disent à propos de nos budgets. Je me dis, y vont pas très bien comprendre, non plus, comment suivre des… les programmes, puis voir si y font bien les choses."
>
> *("There is…a certain control by the federal government, but I am a bit skeptical, seeing the lack of understanding, of… what Housing First is, which is reflected in what they tell us about our budgets. I tell myself, they're not going to understand very well, either, how to follow…the programs and then check if they are doing things correctly.")*

Some stakeholders also had the impression that the *Agence*, perhaps in order to reduce opposition to the HPS reorientation, preferred to distribute funds across more organizations, though with inadequate funding for each.

With the dismantling of the *Agence*[14], it is hard to predict how HF funding will evolve in Quebec. At the moment of writing this report, the provincial government has not started financing any type of HF intervention, with the exception of providing some of the funding for *Diogène' Un toit d'abord*, and has not given any signal it intends to do so in the near future. However, the provincial government did agree to the HPS reorientation and publicly defended this decision, arguing that HF is one of the approaches identified in their homelessness action plan.

Forging International Partnerships

According to some stakeholders, the fact that HF is now being applied more widely internationally might have contributed to make it more acceptable to the Québec government or other community organizations. As mentioned earlier in the report, inviting key representatives from Belgium's community organizations and government to Montreal was an occasion to open a neutral space where HF could be discussed for what it is, without the political dimensions it is often charged with in Quebec. As previously mentioned, the Belgians' visit was also an occasion to invite several people from various organizations and institutions in Montreal who were relatively unfamiliar with HF. The "Ministre déléguée" responsible for homelessness policy even agreed to open the conference, on November 21 2014, during which the results of AHCS were presented to the Belgian delegation.

Negotiating with Health Authorities

Diogène, in order to maintain its team and services, kept on negotiating with the *Agence*, which constituted at the time, the health authority over Montreal. Diogène's leadership was deeply involved in these negotiations, participating in frequent and prolonged meetings. The fact that participants experienced some problems in being transferred to usual services gave power to their arguments and they were able to position themselves as a team that could assume responsibility for people whom usual services were unable to serve adequately. They also made the point that they developed a team with an expertise that is unique among community organizations. The *Agence* felt that this expertise would be preserved since case managers would work in other teams or organizations. Diogène managed to convince the *Agence* that the case managers' experience would, on the contrary, be diluted and lost in other organizational cultures and that the service philosophy and structure of their organization was in fact one of the key ingredients of their success.

[14] On April 1, 2015, Québec Bill 10 came into effect and resulted, among other significant changes in the organization of the health and social service system, in the dismantling of Québec's health and social service agencies.

Research Results

The impacts of the research results are one of the themes that generated the most different and divergent opinions among stakeholders. Some were definitely more optimistic and felt that the results and testimonies of participants in various events had a decisive impact on expanding HF principles and influencing other services or in the provincial government decision of agreeing to the HPS reorientation. Some felt more specifically that research result presentations that targeted high-ranking government officials and representatives were probably the most effective in changing policy towards HF and the HPS reorientation. For example, in June 2014, just before the official release of the Montreal site final report, key representatives from the provincial government came from Quebec City to meet in Montreal with former AHCS stakeholders as well as federal government representatives. The project and its results were at this occasion thoroughly presented and explained. According to some stakeholders, this might have convinced the Government to adopt HF and agree to the HPS reorientation.

In any case, with the results that were presented in various reports, articles and conferences, it is now hard for anyone to deny that HF is effective and that people can't benefit from it or that it will not work in Montreal. In other words, research efforts have paid off:

> "Oui, je pense que tout l'effort de recherche a fait en sorte que maintenant, c'est difficile pour les gens de dire que, bon, c'est mauvais pour les gens, y vont être dans des appartements épouvantables, vous allez juste faire du tort au monde, là, je pense que les gens peuvent plus dire ça. Maintenant, un endroit dans lequel certains se réfugient, c'est dire, ah oui, ça fonctionne, mais c'est juste pour une infime minorité de la clientèle."
>
> *("Yes, I think that all the research effort resulted in it now being difficult for people to say, well, it's bad for people, they're going to be in awful apartments, you're just going to harm them, now, I think that people can't say that any more. Now, one place that some are taking refuge in, is to say, oh, it works, but it only applies to an infinitesimal proportion of the clientele.")*

Other stakeholders, more pessimistic, feel that in general, research results have been largely overshadowed by all the political tensions surrounding AHCS, as well as protests and denunciations from organizations like RAPSIM, who occupied a lot of space in the public debate, controlled the message more effectively in the media and lobbied much more aggressively than AHCS stakeholders. Moreover, many influential individuals from community organizations and other advocacy groups tend to give much more weight and value to RAPSIM's opinion than to the one that came from AHCS representatives. In this perspective, the research results might be influential and come into play only in

a few years, when the dust will have settled and the model will be discussed for its benefits and limits, rather than over the political issues that surround it.

Some stakeholders point out that while the quality of life improvements of those who benefited from HF in AHCS were tremendous and very tangible, the economic benefits were however somewhat disappointing and not compelling enough for politicians to take the risk of facing the community to force a wider adoption and implementation of the HF model:

> "Je pense que ce que les résultats montrent, c'est que ça coûte pas plus cher, mais ça coûte pas tant que ça moins cher non plus, hein, c'est ça que ça montre, si j'ai bien compris. Fait que c'est sûr que si on avait eu un résultat, à quel point c'est moins cher, beaucoup moins cher, mettons, peut-être… peut-être que ça aurait… les gens auraient été encore plus intéressés, [...]. Mais moi, j'ai l'impression que ça… le résultat est… est pas aussi extraordinaire qu'on s'en attendait en termes de coûts. En termes de résultats, de bienfaits sur les gens, moi, je pense que c'est… c'est vraiment… Fait que, tu sais, c'est… c'est vraiment incroyable, là, pour la plupart des gens, pas pour tous. Mais… mais au niveau des coûts, si on parle juste d'argent, ça… je pense que c'est peut-être pas suffisamment impressionnant pour dire, ah, on va vraiement être attentif à ça [...]."
>
> *("I think that what the results show, is that it doesn't cost more, but that it doesn't cost that much less either, eh, that's what they show, if I understood correctly. So for sure if we'd had a result showing how much less expensive it is, a lot less expensive, let's say, maybe… that would have…people would have been even more interested, , [...]. But as for me, my impression is that…the result is…not as extraordinary as we expected in terms of cost. In terms of results, of benefits for people, personally, I think it's…really…So, you know, it's… really incredible , there, for most people, not for everyone. But… in terms of costs, if we are only talking about costs, there…I think it's maybe not impressive enough to say, oh, we're really going to pay attention to this [...].")*

REFLECTIONS AND LESSONS LEARNED

During the interviews, many stakeholders have said that implementation processes and tools developed are almost as important as the research results. Scientific papers published can confirm the effectiveness of the project from a scientific standpoint and somewhat guide public policies and recommendations. Organizations, on the other hand, are often more interested in “tangible material”: implementation processes and strategies deployed to recruit participants, house them and find landlords and negotiate with them, intervention methods and philosophy, and in the tools used and also written in a language they can understand. It should therefore be a priority, not only to document well the knowledge that was developed during AHCS regarding implementation strategies, but to produce guides or other documents in French that detail how to implement HF and that are easily accessible.

Stakeholders also noticed that case managers or other direct service workers lower in the organizations' hierarchy are often more interested in HF than their senior managers or directors, as they are less connected to the political issues surrounding HF and are less reluctant to question the CoC model. Given the opportunity to learn about HF, they are often surprised to learn that it is not what they had imagined and show a high level of interest. They discover that HF, which they often had initially associated with a top-down approach, imposed by the government with a very rigid structure, in fact shares many core components with the community organizations' philosophy. Indeed, a lot of the components of the HF model, such as harm reduction, focus on recovery, putting the person in the centre of the decision process, etc., are practices that have been developed and put forward by many community organizations during the last decades. In this context, some stakeholders insist on the importance of making “stories of practices” developed in AHCS or other such tools readily available to case managers and direct service workers and to organize knowledge exchange around this issue.

The HF model should also be presented as an approach among many in a broad scope of services, complementary to services and expertise already in place. At the time when the interviews were conducted, many community organizations and lobbying groups still felt that HF was presented as a one-size fits all solution to homelessness. Stakeholders mention that AHCS failed to convince many of Montreal's key players in homelessness. Recognizing the value and merits of other approaches already in place should be a priority. HF proponents should try to see how the model can be integrated in the current configuration of services; how it can contribute significantly to what is already in place, instead of replacing other services. The challenges met by HF in Montreal were a lesson that the Belgian delegation took good note of, as narrated by this stakeholder:

"Bien, je pense que c'est faire autrement que la façon dont le projet Chez Soi est débarqué à Montréal, à savoir, placer ça vraiment dans une perspective de la complémentarité des approches, puis de valoriser l'expertise des personnes à qui tu parles. [...] quand les Belges sont venus… quand y sont partis, ce qu'y ont dit, c'est OK, ce qu'on retient, c'est qu'y va falloir être super prudents dans la manière de placer le projet à Bruxelles, puis en Belgique. Puis ce qu'y retenaient, c'était à quel point ç'avait été difficile, ici, de travailler, parce que on s'y était très, très mal pris, puis les… les personnes les plus compétentes en itinérance, on se les est aliénées dans la mise sur pied du projet. Donc, eux, c'est devenu leur priorité : OK, y faut qu'on s'assure que tout le monde embarque dans ce projet, puis y voient l'intérêt."

("Well, I think it's to do things differently than the way the Chez Soi project landed in Montreal, that is to say, really place it in a perspective of complementarity of approaches, and then to recognize the value of the expertise of the people to whom you are talking. [...] when the Belgians came…when they left, what they said was, it's ok, what we remember, is that we'll need to be super careful in the way we situate the project in Brussels, then in Belgium. And what they were left with, was to what extent it had been difficult, here, to work, because we had gone about it really, really poorly, and the…most competent people in homelessness, we alienated them in the design of the project. So, for them, that became their priority: OK, we have to make sure that everybody comes along into this project, and sees its value.")

CONCLUSION

In conclusion, the AHCS project intersected with many hotly debated topics, such as the opposition between social housing and private market apartments, between federal and provincial jurisdiction over health, between the widely used CoC model and a model where the participants receive an apartment immediately, etc. It profoundly divided the network of homeless and social services in Montreal and was not merely viewed as another tool or philosophy of services. Some organizations and advocacy groups perceived it as a frontal attack on their services and clients and rallied to adopt a very defensive posture, often without considering the merits of the approach.

The transition from AHCS services to usual services was very difficult for many participants, especially those from the high needs group. According to some stakeholders, the transition revealed that the formal health system is in general, at the present time, poorly configured to deal with persons experiencing complex and multiple issues and not configured to deliver HF services. A major system transformation or a change of culture – nearly a paradigmatic change – would still be needed in the formal mental health system to apply HF more widely. Until this happens, many stakeholders believe that many homeless persons experiencing complex issues will still continue to be served essentially by emergency and crisis oriented services (e.g. shelters, hospitalization, etc.). On the other hand, some local initiatives, such as the SII team at the CHUM/Old Brewery Mission, partly inspired by the AHCS, demonstrate that there is space in the formal mental health system for implementing innovative practices and that given the will to adjust the structure and form the right partnerships, it would be possible to implement it. In the current state of the system however, transformation or the creation of ICM and ACT team dedicated to HF will mostly come from senior levels of management, which are not currently focused on implementing practices such as HF, as a lot of their time, energy and attention are being diverted to the overhaul of the health and social service network prompted by Bill 10.

The enmity of the main advocacy and lobbying group in Montreal towards HF has been an obstacle to sustainability of HF. Resistance is still present among many organizations nearly two years after the official end of HF, but HF is now starting to be recognized as an approach among others, suited for a specific type of homeless person, whom traditional approaches have difficulty helping. This recognition is still very fragile and at risk of dissipating if organizations that receive HPS funding are unable to deliver HF services adequately. Failure might be used by critics to fuel the opposition to the model. In this context, providing effective training in the model and measures to ensure that HF is really applied will be especially important.

The AHCS has definitely left its mark in Quebec. Although this fact has not been highlighted in the report so far, the *Plan d'action interministériel en itinérance 2015 – 2020*, which was released by the Liberal government in December 2014, explicitly includes Housing First as one of the measures (measure 11.5) to be put in place as part of its overall plan to reduce homelessness. While it does not itself provide funding to this end, the inclusion of HF in its plan became its justification for approving the reorientation of part of HPS funding towards HF. Furthermore, the AHCS project proved that the model can be applied with success in Québec. It has influenced other parts of the health and social service system and contributed to the dissemination of the model in France and Belgium. This growing international recognition will inevitably have an impact on the perception of HF in Quebec. It will probably benefit from growing credibility in the coming years, provided that the necessary efforts to promote it and render it accessible to everyone interested are made.

One of the limitations of this report is that no one from the MSSS or Agence was interviewed. Therefore, we do not have access the views and motives of officials who were in place and took the decision to close AHCS.

EPILOGUE

Since the interviews on which this report is based were conducted, a few relevant developments may be noted.

Diogène's Toit d'abord program is still operational. Thanks to HPS funding, six additional HF programs have been funded. Two for meetings of these programs representatives have been established: a "strategic committee", established by the MSSS staff, based at the CIUSSS du Centre-sud-de-Montréal, now responsible for coordinating homelessness services in Montreal; and a community of practice of team supervisors, established at the initiative of one of the funded organizations, Plein Milieu. Diogène has been providing training and coaching to a few of the other new programs. The strategic committee, which includes senior managers of the funded programs, is concerned both with supporting and providing useful information to the programs and with ensuring the sustainability of their programs beyond the end of current HPS funding (i.e. beyond March 31, 2019). Due to the parameters of HPS funding of HF programs, or at least how these parameters have been interpreted in Montreal, none of the programs include a psychiatrist or nurses, so that none target the highest-need people with psychotic illness that AHCS's ACT team was able to house and support.

Aware of this gap in service delivery, the Movement to end homelessness in Montreal released part 1 of its plan to end homelessness at a press conference on December 20, 2015, with the participation and endorsement of Montreal Mayor Denis Coderre. The plan calls for an expansion of HF, for high-need as well as moderate-need individuals, as well as of the PRISM program (which can be viewed as a type of critical-time intervention) in Montreal sufficient to enable 2,000 chronically and episodically homeless individuals to be permanently housed within five years. (Part 2 of the plan, on the prevention of situational homelessness, and part 3, on prevention and social inclusion, are in preparation.) The Mayor has committed $700,000 over five years to help implement the plan. Total estimated cost of part 1 of the plan is $36.9 million, of which $18.8 million is over and above current funding levels. Most of this is to come from the provincial government and it remains to be seen how much will actually be provided.

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APPENDIX A

Table 1 – Diogène ICM Team's Self-Assessment Fidelity Scores

ITEMS	PROGRAM SCORE
Housing Process and Structure	
Housing choice	4
Neighborhood choice	4
Furniture assistance	4
Housing subsidies	4
% income towards rent	4
Time to move into housing	4
% in different types of housing	4
Average	**4.00**
Service Philosophy	
Determination of services	4
Requirements for psychiatric treatment	4
Requirements for substance use treatment	4
Approach to substance use	4
Activities to promote treatment adherence	4
How treatment goals are set	3.6
Life areas targeted for treatment	4
Average	**4.00**
Service Array	
Help to maintain housing	4
Psychiatric services	4
Substance use treatment	2.5
Employment	4
Education	4
Volunteering	4
Physical health	1.6
Peer specialist	NA
Social integration	4
Average	**3.51**
Team Structure / Human Resources	
Targets chronically homeless with mental illness and addictions	4
Client:staff ratio	4
Face-to-face client/staff contacts per month	4
Regular staff meetings	4
Function of staff meetings	4
Client input	4
Average	**4.00**
Total Average	**3.90**

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