

What Happens After the Demonstration Phase?: The Sustainability of Canada's At Home/Chez Soi Housing First Programs for Homeless Persons with Mental Illness

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Abstract This research examined the sustainability of Canada's At Home/Chez Soi Housing First (HF) programs for homeless persons with mental illness 2 years after the end of the demonstration phase of a large (more than 2000 participants enrolled), five-site, randomized controlled trial. Qualitative interviews were conducted with 142 participants (key informants, HF staff, and persons with lived experience) to understand sustainability outcomes and factors that influenced those outcomes. Also, a self-report HF fidelity measure was completed for nine HF programs that continued after the demonstration project. A cross-site analysis was performed, using the five sites as case studies. The findings revealed that nine of the 12 HF programs (75%) were sustained, and that seven of the nine programs reported a high level of fidelity (achieving an overall score of 3.5 or higher on a 4-point scale). The sites varied in terms of the level of systems integration and expansion of HF that were achieved. Factors that promoted or impeded sustainability were observed at multiple ecological levels: broad contextual (i.e., dissemination of research evidence, the

policy context), community (i.e., partnerships, the presence of HF champions), organizational (i.e., leadership, ongoing training, and technical assistance), and individual (i.e., staff turnover, changes, and capacity). The findings are discussed in terms of the implementation science literature and their implications for how evidence-based programs like HF can be sustained.

Keywords Housing First · Homelessness · Mental illness · Sustainability · Implementation science

Introduction

An important question in implementation science is how evidence-based programs can be sustained past the research demonstration phase. While there are examples of how effective programs are either diluted such that they no longer resemble the original program or defunded, research on the sustainability of programs after the demonstration phase is just emerging. By sustainability, or sustainment, we mean program continuation, fidelity, integration into existing systems, and program expansion. The purpose of this paper is to examine the sustainment of the Housing First (HF) programs of Canada's At Home/Chez Soi research demonstration project for homeless persons with mental illness. In the remainder of the paper, we use the terms "participants" or "consumers" to refer to this population.

Housing First

The HF model was conceived and first implemented in New York City (Padgett, Henwood, & Tsemberis, 2016;

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Tsemberis, 2010). HF focuses on specific sub-groups of the homeless population, namely adults with serious mental illness who are considered to be chronically or episodically homeless by virtue of the fact that they account for the majority of days of shelter use, as well as being frequent users of emergency and hospital services (Kuhn & Culhane, 1998). HF is based on the values of consumer self-determination and choice, social inclusion and citizenship over patienthood, and social justice, in which housing is viewed as a right, not a privilege.

Derived from these values, there are four key principles of the HF model: (a) housing and services are consumer-driven; (b) housing and clinical services are separated; (c) a recovery-oriented approach is used; and (d) there is a focus on community integration (Aubry, Nelson, & Tsemberis, 2015). Consumers must have choice over their housing, where it is located, and with whom they live. Since the vast majority of consumers want to live independently in their own apartments (e.g., Harvey, Killackey, Groves, & Herrman, 2012), rent supplements are supplied so that consumers can afford normal rental market housing. This HF approach is referred to as “scattered-site,” because apartments are scattered across geographic communities. Consumer-driven services occur when services are provided by Assertive Community Treatment (ACT) teams or Intensive Case Management (ICM) teams with peer support workers, whereby consumers have choice over their recovery goals and the types and intensity of services that they use. Housing and clinical services are considered separate when housing is rented from commercial landlords (Aubry, Cherner et al., 2015). Unlike services that have requirements for medication compliance and sobriety, there are no service requirements for tenancy other than a weekly home visit. Moreover, services are mobile, rather than located within one’s housing. A person-centered, strengths-oriented recovery approach is used by ACT or ICM workers, not a focus on deficits. Finally, community integration is marked by the dispersal of housing geographically in conjunction with the limiting of apartment buildings to a 20% composition of program participants so that they will live next to and have contact with other community residents.

There have been several recent reviews of the HF literature (Aubry, Nelson et al., 2015; Nelson & MacLeod, 2017; Padgett et al., 2016). Experimental and quasi-experimental evaluations of the original Pathways HF program have consistently shown improved housing stability for HF participants relative to control or comparison groups, while other outcomes (e.g., quality of life) are more mixed. Limitations of these early studies are that they had relatively small sample sizes, were restricted to one program site, and were conducted in collaboration with the program founder, Sam Tsemberis. However, the

results were quite promising as a way to end homelessness, and led to a larger, multi-site, Canadian project conducted by several independent researchers.

Canada’s At Home/Chez Soi Project

At Home/Chez Soi, implemented in five cities across Canada – Moncton, Montreal, Toronto, Winnipeg, and Vancouver – was a randomized controlled trial of HF versus Treatment as Usual (no housing or support provided through this project) (Goering et al., 2011). During the demonstration phase, the project was managed by the Mental Health Commission of Canada and funded by Health Canada. The planning phase for the programs began in the spring of 2008 (Nelson et al., 2013), and the first participants were enrolled in October, 2009 (Goering et al., 2011). Funding was scheduled to end in March, 2013, but was extended to March, 2014. More than 2000 participants were enrolled in the study.

All participants in the HF condition of the project received a rent supplement so that they could acquire housing of their choice from the local rental market. Nested within each of these two HF experimental conditions were two groups of participants: those with high needs, who received support from ACT teams, and those with moderate needs, who received support from ICM programs (Tsemberis, 2010). Both ACT and ICM provide support services, but differ in how services are provided. ACT offers services that are provided by a team that includes specialists; has a low staff to participant ratio (1:10); and operates 24 h per day for 7 days per week. In contrast, ICM provides services through a case manager who often “brokers” services with other agencies; has a slightly higher staff to participant ratio (1:15–20); and operates 12 h per day for 7 days per week (Goering et al., 2011). Additionally, sites had the option of developing a “third arm,” or a HF intervention condition that was adapted to local conditions and needs. Treatment as Usual consisted of mental health and housing services that were available to this population, and these services varied across sites. Such services included shelters, other forms of housing (e.g., congregate housing based on a transitional or “staircase” model), drop-in centers, meal programs, and psychiatric hospitalization.

Research on the At Home/Chez Soi project found that the programs demonstrated a high level of fidelity to the HF model, as determined by an external fidelity assessment (Stefancic, Tsemberis, Messeri, Drake, & Goering, 2013), both initially (Nelson et al., 2014) and after 1 year of operation (Macnaughton et al., 2015).

Moreover, fidelity was significantly and directly associated with positive outcomes, including housing stability, quality of life, and community functioning (Goering et al., 2016). After 2 years, HF participants showed significantly more positive outcomes than Treatment as Usual participants on measures of housing stability in the ACT (Aubry et al., 2016) and ICM (Stergiopoulos et al., 2015) programs.

Program Sustainability

In the past decade, there have been several theoretical, empirical, and review articles dealing with program sustainability (Chambers, Glasgow, & Stange, 2013; Pluye, Potvin, & Denis, 2004; Savaya & Spiro, 2012; Scheirer & Dearing, 2011; Schell et al., 2013; Shediach-Rizkallah & Bone, 1998; Stirman et al., 2012). The most widespread definition of sustainability is that it is "...the continued use of program components and activities for the continued achievement of desirable program and population outcomes" (Scheirer & Dearing, 2011: p. 2060). Implementation science often conceptualizes the life cycle of a program as moving from exploration to implementation to sustainability (Metz & Bartley, 2012), recognizing that there are no neat divisions between stages (Pluye et al., 2004). Moreover, distinctions have been made between sustainability outcomes and processes that promote sustainability (Savaya & Spiro, 2012; Scheirer & Dearing, 2011; Schell et al., 2013; Shediach-Rizkallah & Bone, 1998; Stirman et al., 2012).

Sustainability Outcomes

Scheirer and Dearing (2011) have outlined the following sustainability outcomes:

1. Continued positive outcomes for program participants – this outcome focuses on the individual level and sustained benefits to participants over time that result from program participation.
2. Continued program activities or components of the original intervention – the continued functioning of the program is predicated on obtaining ongoing funding.
3. Maintaining community-level partnerships or coalitions – many complex interventions, like HF, require significant collaboration with community partners to provide needed services for participants.
4. Program diffusion and replication – successful evidence-based programs need not merely be sustained but expanded and scaled up.

Other sustainability outcomes that have been identified include fidelity and systems integration. Program fidelity

means that the program remains faithful to the original program model and is not drastically mutated or diluted such that the post-demonstration program bears little resemblance to the original program during the demonstration phase (Chambers et al., 2013).

Systems integration refers to what has also been termed "institutionalization" or "routinization," suggesting that the program becomes integrated into a larger array of services in a community (Stirman et al., 2012). In the context of this study, systems integration means the adoption and support of the HF approach by mental health and housing systems serving homeless people with mental illness. Goering and Tsemberis (2014) have argued that the HF approach can transform existing housing and support systems from what is typically a "staircase" approach in many communities, in which consumers must move through a set of programs with many rules and restrictions until they are deemed "ready" to live independently. HF disrupts Treatment as Usual by providing consumers with immediate access to the housing and services of their choice and by challenging the existing belief that "professionals know best," a focus on deficits, and the charity model in which housing is viewed as a privilege, not a right.

To date, there has been little research on the sustainability of permanent housing provided during a demonstration project to homeless persons with mental illness. One exception is a study by Steadman et al. (2002) that examined the sustainability of the ACCESS program, a 5-year federal demonstration program in the U.S. for homeless persons with serious mental illness and co-occurring substance abuse that focused on systems integration. While the program model that guided ACCESS systems integration was not specified, the population, the focus on housing, and the research on program sustainability make this research particularly relevant for this study. The researchers visited the 18 ACCESS sites within 6 months of the end of federal funding. While all but one of the sites continued to provide services, there were major changes at several sites. These included staff reductions, a higher participant to staff ratio, a reduction in the number of participants served, changes in eligibility criteria, a broader catchment area, and, in some instances, expanded services. Most sites were able to obtain funding from state or local sources, but in some cases the funding was time-limited.

Sustainability Processes

If the above noted sustainability outcomes are achieved, the question arises as to what sustainability processes or strategies contribute to successful outcomes. Wandersman et al. (2008) have formulated an ecological model of factors that influence program implementation at multiple levels of analysis, including broad contextual factors (e.g.,

funding, policy, research evidence), community factors (e.g., community capacity), organizational factors (e.g., leadership, organizational support), and individual factors (e.g., the capacities of service providers). Sustainability processes include intentional actions designed to promote sustainability, as well as other factors in the ecological context that facilitate or impede sustainability.

Their model aligns well with theory and research on program sustainability (Damschroder et al., 2009; She-diac-Rizkallah & Bone, 1998). In a study of 297 projects, Savaya and Spiro (2012) found that the factors most strongly related to program sustainability outcomes included broad contextual factors (i.e., funding), community factors (i.e., partner involvement), organizational factors (i.e., organizational ownership for the program, leadership), and individual factors (i.e., staff capacity). Unexpectedly, they found that research evidence regarding program effectiveness was not related to program sustainability. In contrast, the most important factor influencing the ability to garner state or local funding for the ACCESS programs in the Steadman et al. (2002) study was, according to participants in their study, the positive outcomes found in the demonstration research. As well, a supportive political environment and positive relationships with policy-makers (macro-level factors) and having local ACCESS champions (community factor) were other important strategies and processes that contributed to sustainability outcomes.

In their review of the literature, Scheirer and Dearing (2011) found evidence of factors that influence sustainability outcomes at multiple levels of analysis. Like Steadman et al. (2002), the state of research evidence on a particular program model was found to be important for sustainability, supporting Wandersman et al.'s (2008) claim that research is an important contextual factor. Another key contextual factor that they reported was resources or funding. Community factors that were related to sustainability included community partner involvement and having local "champions." Organizational factors like leadership, a positive organizational climate, and training opportunities for staff were also important for program sustainability. Staff capacity was an individual factor that was important for sustainability. Scheirer and Dearing (2011) also reported that characteristics of program innovation influenced sustainability. These included the fit of the program with the local context, the ability to maintain fidelity to the program model, and the program model's adaptability to the local context.

Research Questions

While there is some literature on program sustainability and the factors that influence it, research on the

sustainability of housing programs for homeless persons with mental illness is limited to the Steadman et al. (2002) study. In this research, we addressed two questions.

1. To what extent were HF programs sustained in terms of continuation, fidelity, systems integration, and expansion, and do these sustainability outcomes differ by site?
2. What factors facilitated and impeded sustainability outcomes, and do these factors differ by site?

Methodology

Housing First Programs Examined

This research focused on the sustainability of 12 of the At Home/Chez Soi HF programs. Site 1, a small community, had only one program, an ACT program that was part of the trial. There was a third arm implemented in a rural community at Site 1 that was not part of the trial. Sites 2, 3, and 4 all had one ACT program and two ICM programs. In both Sites 3 and 4, one of the ICM programs was locally adapted to address issues of cultural diversity. In Site 5, one ACT and one ICM program were examined. There was a locally adapted ACT program that was in a single site (a hotel), as opposed to using the scattered-site approach. This program was not included in this research because it was not intended to continue past the end of the demonstration phase of the project. In all, there were 12 programs that could potentially have been sustained.

Mixed Methods Approach

A mixed methods approach was used to examine HF program sustainability (Macnaughton, Goering, & Nelson, 2012; Nelson, Macnaughton, & Goering, 2015). Qualitative interviews regarding sustainability outcomes and factors influencing sustainability were used along with an assessment of fidelity using a self-report HF fidelity scale (Gilmer, Stefancic, Sklar, & Tsemberis, 2013).

Qualitative Evaluation of Sustainability

Sampling and Sample

Individual key informant interviews were conducted at each site. Site researchers interviewed the former Site Coordinators, Principal Investigators, and team leads for ACT and ICM programs. They also asked these individuals to suggest other people to interview (e.g., decision-

makers, community partners). Key informants at the national level (e.g., decision-makers within government, Mental Health Commission leaders) were also interviewed regarding sustainability.

Researchers conducted focus groups with staff that had experienced the transition from the demonstration phase to the sustainability phase, and they also conducted focus groups or individual interviews with program participants who continued to receive HF. A total of 142 people were interviewed: 69 key informants, 37 ACT or ICM staff, and 36 program participants.

Data Collection

The research employed document reviews and qualitative interviews. Program leaders were asked to provide documents pertaining to project site funding and budgets for relevant service-provider and housing teams, memoranda of agreements, service operation protocols, and site operation teams' minutes of meetings, both during and after the demonstration phase. Qualitative interviews were used to examine sustainability outcomes, as well as the strategies employed to achieve those outcomes and other factors contributing to them. All interviews were audio-recorded and transcribed. Note that we do not report on the sustainability of participant outcomes, as these outcomes are the focus of other papers. All data were collected between October, 2014 and June, 2016, which was approximately one and a half to 3 years after the end of the demonstration phase.

Data Analysis

The approach to data analysis at each of the sites and for the national level involved thematic analysis (Braun & Clarke, 2006). Site researchers identified “common threads” throughout the data, drawing out significant concepts that emerged from individual interviews along with concepts that linked interviews together. Each site went through a process of member-checking with people who were interviewed to establish the trustworthiness of the data. With the aid of a common template, the qualitative site researchers produced site reports on sustainability (Cherner, Ecker, Rae, & Aubry, 2016; McCullough & Zell, 2016; Méthot & Latimer, 2016; Patterson, 2015; Plenert, Hwang, O'Campo, & Stergiopoulos, 2016). Additionally, a report on national-level policy changes was produced using the same process (Macnaughton, Nelson, Goering, & Piat, 2016).

This paper relied on the site reports and the national policy report as the sources of data, rather than reviewing transcripts or other data from each site. For the cross-site analysis, members of the National Qualitative Research

Team read the five site reports. Next, matrix displays were constructed using the sustainability outcomes and factors contributing to these outcomes as one dimension and site as the other dimension. The cells of the matrix were then populated with data from the site reports. Researchers from the sites reviewed a summary of the cross-site analysis, and their comments were incorporated into the final analysis.

Fidelity Evaluation

A fidelity assessment of continuing HF ACT and ICM programs was conducted using a staff-rated measure of fidelity (Gilmer et al., 2013). This 36-item measure assesses five domains. First, Housing Process and Structure measures the availability of rent subsidies, participant choice over housing, the extent to which participants pay no more than 30% of their income on housing, and how quickly participants are able to move into housing. Second, Separation of Housing and Services taps access scattered-site housing in the community, with no program conditions (e.g., sobriety), a normal tenant lease, and rehousing if the participant loses his or her housing. Third, Service Philosophy includes choice over one's goals, the types and intensity of services, the right to refuse services, and use of a harm reduction approach. Fourth, Service Array refers to the availability of different services (e.g., nursing, psychiatric, employment, education). Fifth, Program Structure measures the size of caseloads, regular team meetings, frequency of contacts with participants, and opportunities for participant feedback.

Factor analysis of the scale by Gilmer et al. (2013) has shown two orthogonal dimensions, the first encompassing the first three domains ($\alpha = .72$), while the second dimension encompasses the last two domains ($\alpha = .78$). Gilmer et al. (2014) found that program fidelity was directly associated with housing stability participants. All items, subscale scores, and the total score were converted to a 4-point scale for consistency with previous HF fidelity research.

The survey was completed by program staff in a group meeting. Staff members were asked to complete the form individually in advance. Most sites held a group staff meeting in which the researcher helped the group arrive at consensus ratings¹ for each item. These data helped to shape questions for the qualitative focus groups, which followed the fidelity assessments. In three of 12 cases, it was not possible to conduct the fidelity assessments because the programs were no longer in operation.

¹ In two of the sites, the survey was sent to the team leads who completed it in conjunction with their staff and then returned it to the research team.

Findings

From the outset of the project, sustainability of the HF teams beyond the end of the demonstration phase in March, 2013 was always a concern. The National Leadership Team of the Mental Health Commission, along with its Government Relations team, began a series of meetings with federal and provincial representatives in 2012 aimed at making decision-makers aware of the At Home/Chez Soi's positive interim results. Sites also established their own sustainability working groups to develop strategies as well as back-up plans for ensuring that participants would continue to have access to housing and support should the HF teams not be sustained come March, 2013.

As a result of these efforts, in the fall of 2012, an agreement was reached between the federal government and the relevant provincial governments, with the exception of one province. In the agreement, the federal government continued to provide funding for the housing subsidies for a transitional year, and each province ensured that support remained in place for the participants. The federal government also offered funding for each Site Coordinator to remain in place for this transitional phase, which ended in March, 2014. In the lead up to March, 2013, and during the transitional year (2013–2014), sites continued to negotiate for the long-term sustainability of the teams. These efforts and their outcomes are described below.

Sustainability Outcomes

Program Funding and Continuation

Nine of 12 HF programs successfully obtained provincial funding to continue. After the demonstration phase, the one HF program in Site 1 was changed from an ACT model to a FACT (Flexible Assertive Community Treatment [van Veldhuizen, 2007]) model. In the new FACT program, participants no longer had to be homeless or at risk of homelessness. Rent supplements for the original participants continued, but if participants lost their housing or wanted to change housing, they would lose the rent supplements. Thus, most participants stayed in the same housing they had during the demonstration phase. Moreover, rent supplements were not available to any new FACT participants. Direct management of the program also shifted from a local community agency to the province's regional health authorities. In Site 2, one ACT team and one ICM team were discontinued due to a lack of provincial support. Participants from these two programs were transitioned to other programs. One ICM program received funding from the regional health authority and continued to operate much as it did during the demonstration phase.

All three programs in Site 3 – one ACT team and two ICM teams – received ongoing funding from the provincial health ministry. While provincial funding was initially uncertain, eventually all three programs in Site 4 – one ACT team and two ICM teams – received both provincial and federal funding, albeit at a reduced level. At Site 5, the one ACT team continued with regional health authority funding, while the ICM team was discontinued. Participants in the ICM program were transferred to other services.

Program Fidelity

The findings regarding program fidelity of the nine continuing programs are shown in Table 1. Across sites, program fidelity scores were consistently high, with average total scores ranging from 3.18 to 3.90 (out of possible score of 4). Using a benchmark score of 3.50 for high fidelity, seven of the nine programs showed high levels of fidelity in their total scores. Changes in funding sources generally resulted in the loss of housing teams or a housing coordinator and the transfer of this role to existing ACT or ICM teams, resulting in lower Housing Process and Structure domain scores for some sites. This is because the lack of specialized housing procurement results in lower choice, which is a key aspect of this domain. As well, some of the programs had no new rent subsidies, so that some participants would need to graduate from the program in order for new participants to enter the programs. Two of the programs at Site 4 and the one program at Site 1 had scores on the Housing Process and Structure domain that were 3 or lower. On the domains of Separation of Housing and Services and Service Philosophy, all of the programs scored above the benchmark of 3.50.

While there were changes in services, fidelity scores on the domains of Service Array and Team Structure/Human Resources generally remained at a high level. The Site 1 FACT program and two of the programs at Site 4 had scores lower than the benchmark of 3.50 for Service Array. This was due to reduced access to substance use treatment, psychiatric services, and services for physical health. Six of the nine programs scored lower than 3.50 on Team Structure/Human Resources, with reduced frequency of contact with participants and changes in team meetings and criteria for admission to programs.

Systems Integration

The level of integration of HF into housing and mental health systems varied across sites. Site 1 showed little evidence of systems integration of HF. The Site 1 report

Table 1 Fidelity domains and scores by program^a

Domains	Site 1 FACT	Site 2 ICM	Site 3			Site 4			Site 5 ACT
			ACT	ICM	ICM (third arm)	ACT	ICM	ICM (third arm)	
Housing process and structure	2.14	4.00	3.50	3.64	3.79	3.00	2.86	3.29	3.29
Separation of housing and services	3.71	4.00	3.71	4.00	3.71	4.00	3.71	4.00	3.71
Service philosophy	3.79	4.00	3.83	4.00	4.00	4.00	3.83	3.83	3.56
Service array	3.44	3.51	3.56	3.40	3.60	3.62	2.73	3.25	3.89
Team structure/Human resources	2.83	4.00	3.67	3.22	3.00	3.61	3.44	3.45	3.44
All domains	3.18	3.90	3.65	3.65	3.62	3.65	3.31	3.57	3.52

^aNote that all items were converted to a 1–4 scale, with 1 being the lowest fidelity rating and 4 the highest fidelity rating.

stated that “the mental health service system has not changed in terms of offering housing services and has not shifted to a HF model” (Site 1 report, p. 3) and “the HF model as a whole was not adopted within [the province]” (Site 1 report, p. 6). The shift resulted in no new FACT participants, including those who are homeless, gaining access to housing subsidies through the program, and existing participants losing their housing subsidy if they lost their housing.

Despite significant resistance experienced from all levels of government and traditional service delivery systems at Site 2, some systems integration was beginning to emerge two years following the At Home/Chez Soi project. This was attributed to enhanced local credibility of Site 2 programs that resulted from the positive outcomes of the research leading to the uptake of the HF model in other countries.

... The Chez Soi project proved that the model can be applied with success in the province. 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 [the province], which 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.

(Site 2 report, p. 28)

Even though permanent funding for HF programs was obtained at Site 3, the Site 3 report stated that the “... HF philosophy has not yet been widely adopted and will remain fragile until we move from a conversation about sustainability to a conversation about system transformation and accountability...” (Site 3 report, p. 6).

Site 4 showed more systems integration with multiple levels of government and community agencies developing a shared vision for HF and shared leadership. This took considerable time to develop, but HF has now become a more routine feature of the mental health and housing

landscape at this site. Like Site 3, the Site 5 report described systems integration as “fragile” (Site 5 report, p. 8). Most of those who were interviewed described systems integration occurring in “small pockets” (Site 5, p. 20) and indicated that HF had not been integrated systemically at local or provincial levels.

Expansion

Housing First programs did not expand for Sites 1 and 3, but did grow in Sites 2, 4, and 5. In Site 1, limited funding, including a lack of rent supplements, was an obstacle to achieving HF expansion in the community. In Site 2, while there was initial government opposition to HF, this has changed over time. One significant boost to HF in this site is the recent reorientation of federal Homelessness Partnering Strategy funding, whereby the 10 largest cities in Canada, which includes Site 2, must allocate 65% of its funding to HF. Due to the proven efficacy of the model through the research and the change in federal funding, new programs that follow the HF model, but are not called HF, have been implemented in Site 2. Provincial policy now explicitly acknowledges a role for HF programs, and the one continuing At Home/Chez Soi HF ICM program leads a HF community of practice in which these new HF programs participate. Moreover, the Movement to End Homelessness in Site 2, with the support of the city, is organizing training and technical assistance in HF.

The lack of expansion at Site 3 was largely due to the fact that:

The teams’ clinical capacity currently far exceeds the number of rent subsidies to which the teams were given access. This has meant that any new referrals would only receive clinical supports from the teams, with no rent supplements to enable access to independent housing.

(Site 3 report, p. 26)

Housing First programs in Site 4 expanded from three to eight programs with funding from the provincial

government and the federal Homelessness Partnering Strategy. Housing Plus, a centralized housing procurement agency for HF programs, and the Health Outreach and Community Support team, were created. The latter team consists of seven professional staff that provides support to the eight HF programs. HF principles have also been incorporated in the city's *Plan to End Homelessness*. Due to sustained rent supplements for At Home/Chez Soi participants in Site 5, some interviewees believed the provincial housing ministry was embracing HF. However, other interviewees indicated that apart from providing rent supplements, which were insufficient in light of Site 5's rental market, real expansion of HF was not happening in the existing service system. Within a health authority that served the suburban neighbors of the city in which the At Home/Chez Soi programs were implemented, there was some expansion of HF.

Factors Influencing Sustainability

Broad Contextual Factors

Research evidence. According to interviewees, the dissemination of research evidence of At Home/Chez Soi impacted sustainability across sites. Ongoing integrated knowledge translation on the part of the At Home/Chez Soi researchers and Mental Health Commission staff came in the form of an interim report and oral presentations that were targeted at government decision-makers and funders. Overall, the research provided evidence to support the model and demonstrate that HF could be delivered in a locally adapted and culturally sensitive way. The positive findings allowed each site to secure funding for a transitional year.

The thing you've got to remember in all of this, is that it only worked because the research was so good... What is absolutely true is that you will never get a short a time frame between research results and implementation as you did in this case. I've never seen it so fast [which wouldn't have happened] if the research hadn't been absolutely spectacular.

(National report, pp. 16–17)

This gave individual sites time to negotiate with provincial governments for more permanent funding, where again, the evidence was instrumental.

There's been a huge impact. I think all of those sector groups have recognized that At Home/Chez Soi demonstrated success with the HF approach. And that overall it had very good results for the participants who were stably housed; for cost savings for the bigger system; and for better matching services to the needs of those

folks. So I think the research definitely demonstrated that...

(Site 4 report, p. 21)

Alignment with provincial and municipal policy and funding. The alignment between HF and policies and funding and the provincial economy were also important contextual factors for sustainability. For example, the change in federal policy played an important role in the expansion of HF in Site 2. Stakeholders at Site 3 emphasized the importance of leveraging "funding and policy windows." One example of a policy window was the Anti-Poverty strategy that government was developing in this province. The Mental Health Commission and the sites created task forces and employed lobbying strategies to take advantage of other policy windows of opportunity. In Site 4, the provincial government, along with the new federal mandate of funding HF programs, supported sustainability. Interviewees also stressed the importance of acquiring early "buy-in" from the provincial government to influence sustainability. In Site 5, the development of ACT teams by regional health authorities provided the policy window that one organization used to gain ongoing funding for its HF ACT team and allowed other communities to develop new HF ACT teams.

On the other hand, a lack of alignment between the HF model and existing policy and funding represented a barrier to sustainability. In Site 1, when the HF program became the responsibility of the province, the disconnect between housing and support policies and services of two departments – Health and Social Development – created "a critical barrier to the sustainability of the HF model" (Site 1 report, p. 25), and no mechanism was made available to provide rent supplements for new participants. As well, the emphasis on ACT and not ICM in provincial policy contributed to the cessation of Site 5's successful HF ICM team. Moreover, pre-existing policy preferences in Site 5 for congregate housing were a barrier to HF.

Across sites, competition for resources, which could be exacerbated by a weak provincial economy, was described as influencing sustainability. The availability and distribution of funding largely depended on the state of provincial and federal economies. The provincial economy for Site 1 was viewed as particularly challenging for sustaining its HF program.

... Key informants and program staff acknowledged that the economic realities of the province and scarcity of funding was an important factor affecting program sustainability. The province was described as "very poor" and "essentially bankrupt," with the demand for subsidized housing exceeding funding availability. Key informants considered the cost of the services delivered

through the At Home/Chez Soi project too expensive to be maintained by the province.

(Site 1 report, p. 25)

Community Factors

Partnerships. Partnerships can be considered both a sustainability outcome and a factor influencing sustainability. We discuss partnerships here because of their pivotal role in maintaining the functioning of HF programs, particularly those that use an ICM approach in which some services are brokered for participants by case managers. Across sites, interviewees emphasized the importance of strong, strategic partnerships at local, provincial, and federal levels that brought together multiple partners, including landlords and property managers, clinical services, hospitals, community agencies, universities, and government bodies. Each of the sites noted specific, yet different *characteristics of partnerships* that were fundamental to creating strong relationships that sustained the programs. For example, in Site 2, international relationships with French-speaking countries (i.e., France, Belgium) implementing HF were noted as enhancing the credibility of the HF concept and the sustainability of one of the HF programs at this site. Site 4 emphasized the importance of creating culturally respectful partnerships between local Aboriginal and non-Aboriginal service agencies, which was viewed as important for sustainability. Interviewees from Sites 3 and 4 emphasized the impact of *relationship history* in sustainability. One interviewee from Site 4 stated:

I think number one, [Site 4] is small; as big as it is, it's small. I think it's relationships. I've been around over 30 years doing stuff in the inner-city... All three of us, we continued working together, we stayed united, we didn't let people piece us off, you know? And I think [that's] because we were innovative and creative thinkers and we wouldn't say no, we wouldn't take no, and we kept on pushing.

(Site 4 report, p. 28)

Organizational Factors

Leadership. Across sites, leadership influenced sustainability – both strong leadership for HF, or lack thereof, and strong leadership against HF. Leadership existed at the organizational level but also at the community level. Specific *individuals, project teams, project committees, community groups, and government affiliates* were mentioned as leaders on service teams and at local, provincial, and federal levels. Additionally, HF champions who built bridges between the At Home/Chez Soi project and government were deemed essential to sustainability.

Interviewees from Sites 1 and 5 emphasized the importance of strong leadership on all levels. For example, the Project Lead, Site Coordinator, Team Manager, Local Advisory Committee, and Regional Directors for the Department of Social Development were seen as essential in Site 1 during the transition phase. In Site 5, a lack of influential leadership was noted during the sustainability phase. For example, with significant reorganization of the local health authority in Site 5, many newer staff members were neither knowledgeable nor experienced enough with At Home/Chez Soi to advocate effectively for sustainability. While some interviewees reported a lack of project leadership by the Mental Health Commission, most reported that senior leadership in the Commission led project sustainability in Site 5. Furthermore, leadership by persons with lived experience in all sites impacted not only the sustainability of the team, but also an expansion of the roles of peers in the mental health system.

In Site 2, the HF ICM team leadership's efforts at ensuring sustained negotiations with the city's health authority largely led to sustainability of this program. However, many political leaders and groups in the province, including one particular association of community organizations with distinct political influence "systematically advocated against At Home/Chez Soi 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" (Site 2 report, p. 17). Additionally, leadership in the regional agency that provides funding and training to health and social service providers in Site 2 strongly resisted HF and At Home/Chez Soi during all phases of the project, and interviewees did not identify any political forces seemingly strong enough to oppose this resistance. In fact, the Site 2 report stated that: "there clearly was a lack of leadership to promote HF in [Site 2], or indeed, to tackle homelessness with a view to ending it rather than allowing it to be maintained indefinitely" (Site 2 report, p. 15). However, in the end, leadership from the surviving HF ICM team is influencing new HF programs funded under the Homelessness Partnering Strategy towards greater fidelity to the HF model.

In contrast, the Site 3 and 4 reports discussed experiences of strong HF advocacy by certain political/program leaders, who helped program sustainability. The Site Coordinator in Site 3 was mentioned several times by interviewees as a particularly valuable advocate for At Home/Chez Soi sustainability. Much of her advocacy skills were attributed to "her past experience working in the Ministry, her ability to leverage the relationships that she had with government officials, and her understanding of the importance of involving key individuals early in the sustainability conversation" (Site 3 report, p. 18).

Similar strategies were employed in Site 4, whereby some senior-level leaders, at both the local and provincial levels, withdrew from direct involvement in the project and returned to their governmental roles, where they were able to successfully advocate for project sustainability from within the system. Furthermore, in addition to strong and sustained leadership from local Indigenous communities in Site 4, all three team leads remained on the teams during the transition phase. Their sustained leadership in the face of funding cuts and high staff turnover helped ensure program sustainability and continuity in service delivery.

Ongoing training and technical assistance. Most sites referred to *ongoing training and technical assistance* as a critical influence on sustainability. Site 3 interviewees referenced national and regional level funding provided for training and technical assistance, which helped support and sustain communities of practice using HF. Both Sites 1 and 3 emphasized the importance of providing ongoing training and technical assistance, especially with staff turnover during the sustainability phase of the project in order to orient new staff to the HF model. One Site 3 participant said:

One of the things that we've made sure we're going to have done is the new staff coming in [...] they're going to have to go through getting the HF training to make sure they're up to speed and even offer it back to some of the original staff because it's been awhile and we want to make sure that everybody is in compliance with what it is we're trying to do with the program.

(Site 3 report, p. 20)

Due to a lack of financial resources during the sustainability phase, in contrast to the demonstration phase, limited training was provided for many staff members and managers at Site 1, and there was a noteworthy lack of training in the new FACT model.

Individual Factors

Staff turnover, changes, and capacity. Staff turnover and staff changes adversely impacted staff capacity. In turn, diminished staff capacity presented challenges for sustainability, particularly as it applied to ensuring program fidelity. Site 1 interviewees reported losing key staff members, including their vocational coordinator, housing coordinator, and the physician who was the clinical lead for the HF ACT team. They created a new FACT service delivery team, allowing for larger caseloads, to replace the ACT team through the transition funding received from two regional health authorities. Original ACT team members had to reapply for their positions, resulting in only four team members, plus peer

support staff, remaining on the team. Regarding staff turnover and staff changes, one Site 1 participant stated:

When we lost our housing coordinator, some relationships that were built with landlords [were lost]. She had all the information. So the minute there was an issue, we would contact her, she would let us know who could deal with it. When this whole transition started and we lost that key person, we lost a lot of ... connections.

(Site 1 report, p. 20)

A year following the end of At Home/Chez Soi, the Site 2 HF ICM team that continued managed to retain 100% of its staff from the demonstration phase. Site 3 interviewees noted some staff turnover, which they believed could "threaten the knowledge base that the service teams have built up over the years of the project" (Site 3 report, p. 20). The highest level of staff turnover was observed in Site 4, with almost 100% staff turnover in one of its HF ICM teams. A loss of some cultural programming was related in part to this loss of staff, along with funding constraints. Despite the large staff turnover, the team leads at Site 4 were retained, which was important to maintaining the integrity of the supports moving forward. Staff changes included the loss or change in role of the housing coordinator at several sites. Staff turnover and staff changes led to new staff that had no institutional memory of or training in the HF model and its implementation. This led to diminished staff capacity, which underscores the importance of training and technical assistance in the HF model.

Discussion

In this section, we discuss the types of sustainability outcomes that were observed, the factors that contributed to them, and how they varied by site.

Types of Sustainability Outcomes and Contributing Factors

Program Continuation

Overall, there was a high level of program continuation across the sites (nine of 12 HF programs). Moreover, these findings were obtained over a longer time period (one and one-half to 3 years) than the previously cited ACCESS program (Steadman et al., 2002), which only followed programs for 6 months. Two of the discontinued programs were in Site 2. Bringing HF programs into this site was contentious from the outset, due to political

opposition at the provincial level and local opposition from the social housing sector (Fleury, Grenier, Vallée, Hurtubise, & Lévesque, 2014). While there were HF champions and leaders who advocated for the sustainability of HF, provincial and local opposition was much stronger immediately following the end of the At Home/Chez Soi project and was responsible for the discontinuation of two of the three HF programs at this site. One HF ICM program at Site 5 was the only other program that was discontinued. At this site, ICM programs were not part of provincial policy and the housing sector in this community favored congregate housing programs over HF. Thus, both broad contextual factors and community factors were mostly responsible for program discontinuation.

For the nine programs that were sustained, there were several contributing factors. The first factor was the strength of the research evidence regarding HF and integrated knowledge translation strategies that were used with local, provincial, and federal policy-makers. Similarly, Steadman et al. (2002) found that research evidence was the most important factor in obtaining funding to sustain the ACCESS programs in the U.S. In both instances (ACCESS and At Home/Chez Soi), project leaders had to rely on interim findings to achieve sustainability, since using final results would have been too late. Additionally, we found that integrated knowledge translation was important for communicating the research findings to decision-makers and persuading them that HF was a program that could rapidly end homelessness (Bullock, Watson, & Goering, 2010). Second, sustained HF programs aligned with provincial policy initiatives in homelessness and mental health. Third, HF champions, partners, and leaders were able to seize upon these policy windows to advance the program sustainability (Kingdon, 2005).

Program Fidelity

While the nine programs that were sustained maintained relatively high levels of fidelity to the HF model, there was variability in fidelity by site. Site 1 had a lower level of fidelity on some domains. This reflected the precarious nature of funding for rent supplements and the shift from ACT to FACT as the support model. Once again, broad contextual factors accounted for this impact (Wandersman et al., 2008). The provincial government did not embrace HF; there was a disconnect between the housing and health departments; and the provincial economy was weak. Site 4 had one HF ICM program that was relatively low in fidelity. This was due, in large part, to the fact that there was 100% staff turnover in this program.

Several programs maintained a high level of fidelity. Partnerships, program leadership, ongoing training and

technical assistance, and provincial funding for rent supplements were important factors in sustaining program fidelity through the transition from the demonstration project to routinized programs. Unlike the U.S., which has had Section 8 rent supplements through Housing and Urban Development (Tsemberis, 2010) for many years, Canada has not had a similar policy, which is essential for HF. Thus, new policies and funding mechanisms had to be put in place at both the provincial and local levels to create rent supplements, both to maintain housing for At Home/Chez Soi participants, and to bring new participants into housing. Partnerships are important for HF fidelity and especially for the Service Array domain because HF programs, particularly HF ICM programs, rely on other services and supports in the community. Leadership is also important because leaders strive to ensure that the HF model is being followed. In Site 2, HF program fidelity was due largely to the leadership of the HF ICM program. Finally, training and technical assistance is critical to keep staff skills sharp and to maintain training with new staff, given the inevitable staff turnover that occurs.

Systems Integration

While At Home/Chez Soi brought a new approach to housing and mental health services that is rooted in values, principles, and evidence (Goering & Tsemberis, 2014), the extent to which HF transformed existing systems was limited 2 years after the demonstration phase. The above-mentioned challenge in making portable rent subsidies a routine part of housing and mental health policy is one example. At best, HF systems integration and transformation in most sites was described as “fragile.” Site 4 was the one exception to this pattern. In Site 4, multiple leaders, partners, and champions, including the Aboriginal community, pushed for broader adoption of the HF approach. These players were able to take advantage of policy windows (Kingdon, 2005) at the federal level (i.e., the federal shift in funding to HF), the provincial level (i.e., the formation of a new government body), and the municipal level (i.e., the city was the body that allocated federal funds) to advance HF. While policy alignment and community support were important, so was the flexible nature of HF, which was successfully adapted in the demonstration phase for the Aboriginal community in Site 4.

Expansion

Similar to systems integration, there was limited evidence of expansion of HF. The greatest evidence of expansion came from Site 4, where five new HF programs were created. Again, policy alignment, community support, and

the ability to adapt HF to different populations accounted for this expansion. There was also some evidence of expansion in Sites 1, 2 and 5. In Site 2, this occurred through the change in federal funding and the leadership of the one HF ICM program. In Site 5, expansion occurred in neighboring suburban communities. This expansion was facilitated by provincial mental health policy that promoted the ACT model and through the availability of training and technical assistance in HF. While expansion was not immediately evident within most of the sites 2 years after the demonstration phase, this is beginning to change in many Canadian communities. The Mental Health Commission funded training and technical assistance in HF for 18 Canadian communities over a 3-year period (2013–2016), and, more recently, the Canadian Alliance to End Homelessness has assumed the lead on providing HF training and technical assistance to even more communities over a two and half year period (2016–2018). Furthermore, there is continuity in the training and technical assistance program with HF founder, Sam Tsemberis, as the lead consultant and trainer for both the Mental Health Commission and the Canadian Alliance to End Homelessness efforts.

Conclusions

Both this study and the Steadman et al. (2002) study show that programs can obtain state/provincial funding to sustain programs and that research evidence is important for convincing governments to fund these programs. The discrepancy between our results and those found by Savaya and Spiro (2012) (i.e., that research evidence was not important) may be explained by our findings, which show that research evidence, while a key factor, is not sufficient in and of itself to achieve sustainability. Additionally, this study found that ongoing relationships between researchers and decision-makers and integrated knowledge translation strategies in which research evidence is expediently communicated to decision-makers is important for sustainability (Bullock et al., 2010). We also found that while evidence is important, it must be aligned with government policy for sustainability to occur (Bogenschneider & Corbett, 2010).

A novel contribution of this study is that we examined additional sustainability outcomes, including program fidelity, systems integration, and expansion 2 years after the end of the demonstration phase. There is a distinct possibility that during the sustainability phase a program can “drift” away from the original model (Johnson, Parkinson, & Parsell, 2012). A crucial factor to help ensure fidelity is ongoing training and technical assistance, both for continuing and new staff (Tsemberis, 2010). Future research needs

to continue to evaluate program fidelity in studies of sustainability. Systems integration and program expansion proved to be more difficult program outcomes to achieve in the short-term. It may be too early in the systems change process to expect more transformative change. Perhaps further ongoing integrated knowledge translation activities, supported by a broad coalition of stakeholders who desire change, are needed to precipitate a “tipping point” that creates broader systems change (Lee & Westley, 2011).

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Conflicts of Interest

The authors have no conflicts of interest.

Ethical Approval

The research was approved by the Research Ethics Boards of the researchers’ universities.

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