Assertive Community Treatment Teams Supporting Vulnerable Client to Maintain Housing

By

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Reconciling the Variance: Assertive Community Treatment Teams Supporting Vulnerable Clients to Maintain Housing

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Abstract

In British Columbia, approximately 11,750 adults with severe addictions and/or mental illness are homeless. People who live with mental illness or the ill social or physical effect of substance use represent a sub population of people who experience homelessness. Many factors have contributed to poverty and homelessness among people who are mentally ill and to the neglect of their physical and mental health needs. A key factor has been the policy decision to de-institutionalize mental health services in British Columbia from the hospital to the community setting. Individuals living with mental illness were discharged from the hospital into the community, where housing is expensive and individuals have limited opportunities to earn an adequate income. Moreover, the community setting lacked the infrastructure to support and promote the health of severely mentally ill individuals. In the studied region, Assertive Community Treatment (ACT) teams have been established to work with individuals to break the cycle of homelessness, mental illness, and addiction as well as to support the improvement and maintenance of the mental and physical health of these individuals living in the community. Among the criteria for care by these regional teams is chronic homelessness caused by the barriers of mental health and addiction.

In this grounded theory study, I explore how four regional ACT teams support their clients to maintain housing. In addition to examining the successes and challenges experienced by ACT team members, I consider the strengths of the team as they attempt to provide a supportive infrastructure that enables clients to maintain housing. Data were collected from four ACT teams in the region. The data collection involved two focus group discussions, three observational sessions with team members in the field, twelve one-on-one interviews, and a review of documents and reports. Data collection and analysis occurred concurrently, and guided further interviews. Through systematic analysis a theory was constructed form the data.

In this study, I explore and analyze the issues that team members encounter and how they resolve them. I also take into account the beneficial outcomes of their complex work to produce a grounded theory explaining how ACT teams assist clients in maintaining housing. The knowledge gained during this study can be used to inform practice guidelines and policy development for the ACT teams. This study also contributes to the evolving body of knowledge that may strengthen provincial initiatives to break the cycle of homelessness. This work also contributes to current discussions on how to provide optimal housing support to individuals with severe mental illness and/or addiction issues.

Keywords: Assertive Community Treatment Maintaining Housing

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Chapter One: Introduction

This research study focuses on the work of four regional Assertive Community Treatment (ACT) teams to support their clients to remain housed. ACT teams are interdisciplinary and were established to provide community support to people who live with severe mental illness, who do not consistently engage with mental health services (Burns & Santos, 1995; Marshal & Lockwood, 1998; Stein & Test, 1980). Some clients supported by the ACT teams studied here also experience health and social issues related to substance use, and many have experienced chronic homelessness. However, people living with mental illness represent a sub-population of the larger population who experience homelessness.

The primary causes of homelessness are policies that perpetuate poverty (Echenberg & Jensen, 2009; Klein & Pulkingham, 2008) and policies that have led to the lack of affordable housing in Canada (Gaetz, 2010). Homelessness affects a wide range of people (Klein & Pulkingham, 2008; Patterson, Somers, McIntosh, Shiell, & Frankish, 2008), most of whom are poverty-stricken. However, not all people who experience homelessness are mentally ill. Individuals who live with a disability, mental illness, or addiction represent a subgroup of the homeless population. People who live with mental illness have an increased risk of homelessness because of judgmental societal attitudes toward them (Clark & Row, 2006; Corrigan & Watson, 2002; Csiernik, Forchuk, Speechley, & Ward-Griffin, 2007). Moreover, people who use substances encounter barriers to housing because of the stigma associated with substance use (Ahern, Stubes, & Galea, 2007; Corrigan & Watson, 2002; Room, 2005). In a tight housing market, such as that in British Columbia (BC) where the cost of rental housing is high and vacancy rates are low, the most desirable tenants are given priority for housing. This research study focuses on the efforts of ACT teams to keep their clients housed while concurrently meeting their responsibility to provide mental health services.

People with severe mental illness have not received the clinical or social support they require to maintain their health (Chudnovsky, 2008; Patterson et al., 2008). Approximately 20 years ago, a policy decision was made in BC to de-institutionalize both mental health services and the client population served by these institutions. Consequently, mentally ill individuals were discharged from the hospital directly into the community (Chudnovsky, 2008). However, this policy was implemented without infrastructure to promote the health of severely mentally ill individuals or strategies for their integration into the community (Patterson, et al., 2008).

Subsequently, ACT teams were established to provide integrated services to those individuals. This issue was discussed in the BC Legislative Assembly:

> One of the reasons we face the crisis of homelessness that we have today among people who have mental illness is because of the deinstitutionalization of those with mental health problems in this province. We promised people with mental health problems that when the large institutions were closed—as they should have been closed; that was an appropriate public policy decision—there would be programs and supports at the community level that would provide for them in a way that made sure their needs were met. That didn't happen, and as a result, many of those people who have mental health problems today face homelessness (Chudnovsky, 2008).

People with mental illness were discharged into the community, where housing was extremely expensive and lack of affordability was a fundamental issue. Consequently, their basic social needs were not met. Homelessness, for this population of people, persisted as a dehumanizing effect of deinstitutionalization.

Although an accurate number of people affected by this policy has not been established, it has been estimated that 11,750 adults who experience severe addictions and/or mental illness (SAMI) are “absolutely homeless” (Patterson, Somers, McIntosh, Shiell, & Frankish, 2008). This number was extrapolated from the prevalence of mental illness within the general BC population. The researcher's definition of SAMI included the major Axis I disorders defined by the Diagnostic and Statistical Manual (DSM-IV-TR), which include schizophrenia. Their definition widens to include people living with severe forms of substance use, as well as anxiety, mood, and eating disorders and who are severely affected by symptoms (Patterson et al., 2008). These authors also acknowledged that the reasons for homelessness experienced by people with SAMI are multifactorial and rooted in limited income, precarious housing circumstances (Patterson et al., 2008), and poverty (Condon & Newton, 2007; Klein & Pulkingham, 2008; Patterson, 2008; Wallace, Klein, & Reitsma-Street, 2006). Canadian housing policies have reduced investment in social housing, led to the diminished availability of affordable rental housing (Gaetz, 2010; Rijordan, 2004), and caused homelessness. These factors have shaped the context in which the studied ACT teams work, which challenges them in stabilizing their clients in appropriate housing.

ACT teams were established in BC primarily to provide infrastructure to support adults experiencing mental illness in the community (Patterson et al., 2008). ACT teams also became part of the initiative to address the issue of homelessness experienced by this population (BC Ministry of Housing and Social Development, 2009; Patterson et al., 2008; Ministry of Health, 2013; Regional Report, 2012). The ACT teams in the region focused on in this study provide clinical services to clients in the community who suffer from mental illnesses and/or addictions and experience chronic homelessness. Currently in BC, 13 ACT teams target clients who are severely and persistently mental ill and/or abuse substances (Ministry of Health, 2013). However, as discussed in the literature, ACT teams were initially created to support clients who had a primary diagnosis of severe mental illness (Burns & Santos, 1995; Marshal & Lockwood, 1998; Stein & Test, 1980). Nevertheless, these ACT teams now support a broader client population.

The regional ACT teams that participated in this study use the following criteria for the admission of clients: 50-plus bed days on a psychiatric ward in the past 24 months or a high volume of days spent in emergency rooms; short-stay psychiatric bed or acute care admissions; frequent encounters with emergency services (police, fire, and ambulance); frequent use of detox, sobering centers, and shelter beds; chronic homelessness because of mental health, addiction barriers, and concurrent disorders (e.g., mental illness and substance use); and on-going involvement with the courts and the legal system. Typically, these clients live with complex health problems and high levels of associated disability. Because of these admission criteria, the participating ACT teams support a broad and heterogeneous population of clients.

Initiatives at national and provincial levels have tackled the issues of homelessness and poor health among people with mental illness. In the region where this study was conducted, municipal plans focus on resolving homelessness in a broad population of people among which exists a subpopulation of people with severe mental illness that are supported by ACT teams. Housing providers in the studied region claim to use the HF model as a framework for service delivery (Regional Report, 2012).

Housing First

In the studied region, ACT teams are identified as part of initiative to break the cycle of homelessness (Government of British Columbia, 2008). People who are housed as a result of the regions HF initiative and who are identified requiring support, beyond the capacity of what the participating program agency support staff can provide, are referred to the studied to the ACT teams for support (Regional Report, 2012[1]). Therefore, in supporting their clients to remain housed, ACT teams nominally work within the context of Housing First (HF).

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[1] Citation withheld so as not to identify the region

HF programs are described in the literature as providing housing that is not contingent upon treatment for mental illness or substance use (Padgett, Gulcur, & Tsemberis, 2006; Tsemberis, 2010). HF is a paradigm shift from the more widely used treatment-first model, in which housing is contingent upon accepting treatment (Johnsen & Teixeira, 2010). Almost all the original work and evidence for HF focuses on housing people who have a primary diagnosis of mental illness, although some may also experience co-occurring substance use (Gulcur & Tsemberis, 2006; Tsemberis, 2010). I will now introduce some tenets of the HF program, as described in the literature. However, it should be noted that this program has been implemented in various forms in different regions of the world (Pleace & Bretherton, 2012). In studying the regional ACT teams work to support clients to maintain housing I gained insight as to how HF has been implemented in the region. However, the implementation of HF in the region is not the focus of this study.

Founded in 1992, the inaugural HF program, Pathways to Housing First (PHF) was established in New York to house people with a primary diagnosis of severe mental illness who could also experience co-occurring substance use (Gulcur & Tsemberis, 2006; Padgett, Gulcur, & Tsemberis, 2006; Tsemberis, 2010). The HF approach is underpinned by the twin premises that housing is a human right and that people should have autonomy in their housing decisions. Thus, clients should have choices with regard to both the type of housing and its location (Stefanic & Tsemberis, 2007). In particular, in addition to housing, clients should be able to choose the extent to which they engage in treatment. Housing is not contingent on acceptance of treatment for mental illness or substance use (Padgett et al., 2006; Tsemberis, 1999; Tsemberis & Eisenberg, 2000). The clients of the PHF program are referred to as consumers. They are governed by the rules of New York's Residential Tenancy Act, although two additional conditions are placed on them. First, consumers agree to participate in a money-management program to ensure their rent is paid and the second is to agree to a visit from the PHF agency staff (Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005; Pearson et al., 2007; Phillips et al., 2001).

Since the inception of the PHF program, HF programs have been initiated throughout the USA, Canada, and Europe. Many of these programs differ from the inaugural PHF, and they have been implemented and adapted to suit local program structures and philosophies (Pleace & Bretherton, 2012). The type of housing provided and the level of on-site support varies (Pearson, Montgomery, Locke, & Buron, 2007). In Canada, fidelity scales are being developed to assess the degree to which a housing program matches the principles of HF (Gaetz, Scott, & Gulliver, 2013; Nelson et al., 2012).

Housing First and Assertive Community Treatment

Clients of PHF programs were offered the support of the ACT teams (Greenwood et al., 2005; Padgett, Gulcur, & Tsemberis, 2006; Pearson, Montgomery, & Locke, 2009). Although PHF is a separate program, HF staff and ACT team members worked closely together. In the case of the PHF program, the refusal of treatment or the services of the ACT team did not preclude the clients from housing. In the research study I conducted, I examined the ways in which the participating ACT teams support their clients to remain housed in the context of the region's HF program.

HF is a paradigm shift from the continuum of care housing approach, in which being housed is contingent upon treatment (Padgett et al., 2006) and abstinence from substance use. In the continuum approach, the individual's response to treatment determines his or her progress through the housing continuum from group living under close supervision to independent living in a secure environment (Padgett et al., 2006; Kyle & Dunn, 2008; Parkinson et al., 1999; Tsemberis et al., 2004; Ridgway & Zipple, 1990). In the continuum of care housing approach, noncompliance with treatment at any point along the housing continuum can result in a delay in moving to the next stage or expulsion from the program

(Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005; Tsemberis & Eisenberg, 2000). The continuum of care approach is based on the premise that individuals with severe mental illness and substance use issues are not ready to live independently in regular housing until their mental illness and/or substance use are treated, and therefore compliance with a clinical regime is required.

In contrast, the HF approach places on the consumer only the constraints of money management and regular casework. By providing housing first instead of treatment first, HF represents an inversion of the traditional approach to the provision of mental health and addiction services. In addition, HF houses clients directly from the street or the institutional setting, instead of waiting until they are deemed “housing ready.” As discussed earlier, consumers are offered the services of an ACT team to support their recovery and integration into the community. Although there is discussion in the PHF literature about ACT teams acting as a community support for clients with severe mental illness, there is very little mention of HF in the ACT literature. This implies that ACT programs do not necessarily focus their activities or align themselves with HF. ACT programs were established decades prior to HF and have their own framework and set of program standards. Housing support is only one of the many services provided by ACT teams. Not all HF programs use ACT teams to provide clinical support; some use other services (Pearson et al., 2007). In the region where I conducted research, clients who require intensive support to remain housed and cannot be supported by existing services were referred to the ACT teams (Regional Report, 2012). HF and ACT teams are separate programs and initiatives and thus are generally not integrated.

However, the inaugural PHF program worked closely with ACT teams to provide clinical support to their clients and although the programs were separate they were integrated and shared the same program philosophies. In order to work within the HF context, both the ACT program philosophy, and the work of the staff had to become aligned with the PHF program model. Because the HF program emphasizes client choice in treatment decisions, when psychiatrists and clinicians join an ACT team that is affiliated with the PHF housing program, they receive training in harm-reduction practice and techniques, such as motivational interviewing (American Psychiatric Association, 2005, p. 1034). According to Tsemberis (2010), in the case of PHF, the ACT program moved away from the medically based model of clinician as expert to a model in which clients are active decision makers in all aspects of their care, including the type and intensity of the service they need (p. 95). PHF and ACT are aligned in supporting clients in their recovery from substance use, their management of mental illness, and their integration into the community (Tsemberis, 2010). The inaugural PHF program subscribed to a clear philosophy of harm reduction (Tsemberis, 2010; Tsemberis, Gulcur, & Nakea, 2004) program. In the context of PHF the ACT teams also subscribe to a philosophy of harm reduction and also employs a substance-use specialist as part of their team (Tsemberis, 2010, p. 115). However, harm reduction is not necessarily a principle of practice used by all ACT teams, and neither is the use of a substance-use specialist.

Harm reduction

Harm reduction refers to policies and programs that aim to reduce the harm associated with the use of psychoactive substances at individual, social, and economic levels. The approach is based on a strong commitment to public health and human rights (Canadian Center on Substance Abuse [CCSA], 2008; International Harm Reduction Association [IHRA], 2006). ACT teams working within the PHF context place no expectations or obligations on the individual to abstain from the use of substances. The practice of the PHF program is in keeping with a harm reduction approach to the provision of services (Lenton & Single, 1998; McNeil & French, 2007; Riley & O'Hare, 2000). The

HR approach is offered to individuals who are not able or willing to cease their substance use (CCSA, 2008). Guided by the philosophy of harm reduction, the practitioner shifts the focus from insisting on abstinence to working with the client to reduce individual risks of harm that can result from substance use (CCSA, 2008; McNeil & French, 2007). Such harm may include overdoses, abscesses and cellulitis, sepsis, HIV, Hepatitis C (Hunt, 2003; Kerr et al., 2004), respiratory problems, and mental health issues (Hunt, 2003). Practitioners remain non-judgmental in their client interactions (CCSA, 2008; IAHR, 2006; Keane, 2003; Marlatt, 1996) and are non-moralistic (CCSA, 2008) and neutral in their approach, neither condemning nor condoning substance use (McNeil & French, 2007, p. 6). There is an understanding that any positive change that an individual makes to reduce harm is significant (IAHR, 2006). The focus is on improving health instead of on the unrealistic goal of attaining perfect health (McNeil & French, 2007, p. 6). Nonetheless, people who use substances need a stable living arrangement to improve their health and to work toward recovery from addiction, if that is their goal. Offering housing first without expectations of abstinence or treatment is essential to the individual's health and safety.

Assertive Community Treatment Teams

The ACT model was designed by Stein and Test during the 1970s in Madison, Wisconsin to provide comprehensive community outreach services primarily to clients with severe mental illness, following their de-institutionalization from psychiatric hospitals to their communities (Stein & Test, 1980). In the western world, this process of de-institutionalization led to the premature discharge of increasing numbers of inpatients without community support. Many faced and continue to face homelessness and/or incarceration (Heart, 2009; Patterson, 2008). Following the initial positive experiences of the Madison ACT model, during the past 30 years it has been implemented in many US states and European countries, as well as New Zealand, Australia, and Canada. Over a six-year period starting in the late 1990s, the Ontario government established 59 ACT teams throughout that province (George, Durbin, & Koegle, 2009), and there are now at least 88 teams in Ontario. Although the admission criteria vary across ACT programs, services are usually reserved for clients with severe mental illnesses, such as schizophrenia, bipolar disorder, and major depression. Although most clients have a diagnosis of co-occurring substance use (Tsemberis, 2010, p. 94), the key factor in the development and implementation of ACT teams is the provision of community support to people whose primary diagnosis is severe mental illness (Stein & Test, 1980).

ACT teams and Pathways to Housing First Program

As discussed previously, ACT teams have been an integral part of the inaugural PHF initiative. The founder of the program, Sam Tsemberis, emphasized the need for the separation of housing from treatment. The PHF program provided housing in apartment buildings without on-site clinical support staff. The consumers lived independently, and the services of the ACT team were offered to clients assessed by the PHF program case manager as requiring clinical support (Tsemberis, 2010). Both the ACT teams and agency staff working in PHF program adopted a HR approach in their practice and involved their clients in decision-making and choice with respect to housing type and the extent to which they engaged in treatment.

Because HF and ACT teams are separate programs initiatives, they are generally not integrated. ACT teams tend not to focus on HR practices, but on treatment and recovery. This means that ACT teams in a HF environment need to operate differently from ACT teams in a non-HF environment.

ACT in British Columbia.

ACT teams were established in British Columbia to provide a program of community support to people with severe addictions and mental illness (SAMI) and who comprise a segment of the homeless population. In 2008, the BC Ministry of Health Services and the Ministry of Housing and Social Development formed a coalition to provide housing, mental health, and social services to “vulnerable citizens” (BC Ministry of Housing and Social Development, 2009, p. 6). These vulnerable citizens included people with addictions and mental illness. This is part of BC’s shift to HF, which prioritizes housing for homeless people, regardless of barriers, such as addictions, and is followed by support services to help them regain independence (Ministry of Health Services BC, 2009, pp. 4–6). The province also created ACT teams to support such vulnerable people. In BC, the ACT teams are multidisciplinary mental health teams that use the ACT model, which is an evidence-based model of practice (Alfred, Burns, & Phillips, 2005). The ACT model is considered best practice for providing services to this severely disadvantaged population.

The BC Ministry of Housing and Social Development document, *Putting Housing First*, mandates ACT teams as follows: The teams ensure that people with mental health challenges remain housed, thus reducing the strain on emergency services dealing with mental health crises. The teams work with people living with severe mental illness to help them improve their mental health, manage other health problems, and prevent hospitalisation. A small group of professionals, such as a psychiatrist, nurse, counsellors, and outreach workers, provide 24-hour emergency care and continuing follow-up services. Clients receive the individualized care they require to participate in ongoing treatment plans and services (BC Ministry of Housing and Social Development, 2009, p. 5).

In BC, ACT teams were established in Victoria, Nanaimo, Vancouver, Prince George, Burnaby, and Kelowna (Walker, 2009), and teams continue to be established in other BC communities. When they were implemented in in Victoria, Nanaimo, and Vancouver, the ACT teams received both provincial and national media attention (Chan, 2010; Hunter, 2009; Walker, 2009). The BC provincial government considers ACT teams part of the solution to the problem of homelessness among severely mentally ill people. Although the teams cannot address the underlying conditions of poverty or the lack of affordable housing, they are mandated by the provincial government through the regional health authority to provide comprehensive services to support severely mentally ill people in the community to remain housed and to reduce the strain on emergency services dealing with mental health crises (BC Ministry of Housing and Social Development, 2009). ACT services include the promotion of the health and wellbeing of clients, including their recovery from mental illness and substance use. The problem that this study will address concerns how ACT teams support a diverse population of clients who live with severe mental illness, some of whom may experience health and social issue related to substance use to maintain housing, in an environment where there is a lack of affordable housing.

Purpose of this study

This study explores how four regional ACT teams in BC support their clients to maintain housing. The participants in the study discussed both the successes and challenges they experienced as they worked with their clients to ensure they remained housed. During this study, I explore these challenges and how they could be resolved. I identify the types of support provided by the participating ACT teams to help clients remain housed within the context of HF in this regional setting. I examine the interface between the ACT teams, the housing staff or landlords, and clients with a history of severe mental illness and/or substance use, particularly with respect to their housing situation.

A tenet of the HF program is choice in housing and in accepting treatment (Tsemberis, 2010). Because there is a pronounced lack of affordable rental housing in BC (Patterson, 2007), I examine the degree to which client choice is and could be exercised. Although it was not the main goal of the study, in working with the ACT teams, I gained insight into how HF is implemented in the region and how it relates to the participants' experiences in supporting their clients to remain in housing.

I narrowed the focus of my research from the original question "How do ACT teams support clients to attain and maintain housing?" to "How do ACT teams support clients to maintain housing?" The narrowing of the question will be discussed further in the chapter 3 the methodology chapter. The aim of the study is to explore the ACT team members' perspectives on the work they do, as well as their experiences in supporting clients. I explore the attributes of the program and the services provided to support clients in a population with severe mental illness and/or substance use, which concomitantly experiences high rates of chronic homelessness. I investigate the challenges that the ACT team members face, and I identify the combined professional skills and strengths used by these multidisciplinary teams to keep their clients housed and to help them become independent. In addition, I examine the context in which housing stability is threatened, as well as the factors that promote housing stability. Finally, I generate a grounded theory that describes and explains the ACT teams' process of supporting clients to maintain housing and how this support affects the clients' potential to remain housed.

Significance of the study

The grounded theory generated in this study encompasses the challenges and issues faced by the participants and the resolution and/or management of these challenges. The theory derived from this research could be used as follows: 1) to inform the development of policy and practice guidelines to support members of this population in maintaining housing; 2) to strengthen provincial initiatives to break the cycle of homelessness, addiction and mental illness; and 3) to provide optimal support for the housing of individuals with severe mental illness and/or addiction issues. The results of my research, which were based on the unique perspectives and insights of the ACT team members, will contribute to the large body of knowledge related to supporting people with severe mental illness and/or addictions to obtain and maintain housing. Furthermore, the identification of strategies that support clients in housing could lead to improved outcomes for clients.

Researcher's Background

For over twenty years, I worked with marginalized populations in hospital emergency departments, outposts in Canada's North, and on the streets and alleys of Vancouver's Downtown Eastside. I found that mentally ill individuals who looked unkempt, had no fixed abode, or were suspected of using drugs or alcohol were frequently triaged to the bottom of the patient priority list. Prejudices against the street-involved mentally ill often led to a culture in emergency departments in which these individuals were perceived as undeserving of support. I began to believe that the support of these individuals should include being treated with respect and dignity as well as meeting their basic needs for shelter, food, and safety.

I realized that although there would always be a highly trained team of professionals to provide emergency trauma and medical services, neither the community nor the hospital had adequate, comprehensive resources to promote the health of people who were experiencing homelessness and mental illness. Hence, my focus shifted from trauma and emergency care to preventing disease and promoting the health of underserved populations in the community. I subsequently enrolled in a post-RN BScN program at the University of British Columbia, first focusing my studies on advanced psychiatric nursing and then on areas of community health, including HIV/AIDS management.

During a BScN practicum, I worked with a mental health outreach team in Vancouver's Downtown Eastside and visited clients on the streets and in single-room occupancy hotels. I was appalled by the conditions in which mentally ill people lived. I was disturbed by the number of individuals who had been diagnosed with substance use and were subsequently diagnosed with HIV and/or Hepatitis C. I became aware that people experiencing homelessness and mental illness are vulnerable to theft and manipulation, as well as to acute and chronic illnesses.

After graduation, I worked in a clinic in the heart of Vancouver's Downtown Eastside, where some of the clinic's clients came daily for medication (e.g., psychiatric or anti-retroviral medication). Although the staff worked hard to find housing for these and other clients, there was a lack of safe, affordable housing. However, the clients who were housed often agreed to have a financial worker at the clinic deposit and manage their welfare cheques in order to ensure that their rent was paid. A clinic outreach worker would shop with the client for food, ensure that the accommodation was kept clean, and speak with the landlord when necessary. In the context of this support, I witnessed improvement in the clients' physical and mental health. However, this type of co-ordinated service and supportive infrastructure provided by the clinic, although essential, was rarely available to clients who were not served by the team at this small clinic. While I was working with the BC Centre for Disease Control as a street nurse in the HIV/AIDS Prevention Program, I began to realize that many clients were not only disorganized but often so physically and/or mentally ill that they could not even complete the processes required to apply for welfare or disability benefits.

While working as both a clinical nurse and a street nurse, I witnessed that people's basic needs for shelter, safety, and nutrition were not being met. The lack of safe housing and shelter often exposed mentally ill individuals to serious health and safety risks. I saw the physical health of individuals deteriorate within mere weeks of my initial encounters with them. I wanted to understand the many factors that affected the health and contribute to the marginalization of specific populations, in this case, people who were mentally ill and homeless. During my work for this master's degree, I used various approaches to studying the issue of marginalization related to homelessness and mental illness, including the historical, political, and social contexts of homelessness and marginalization.

I became increasingly interested in the work that was being done in BC to house people. I attended public meetings about the issue and followed newspaper reports on this topic. I became curious about how the work of ACT teams was breaking the cycle of homelessness, mental illness, and addiction. During the 14 weeks of the student practicum for my master’s degree, I worked with an ACT team. I became increasingly aware of the complexity and intensity of the work done by these teams to provide the infrastructure to support severely mentally ill individuals in the community. During team meetings and while working with my ACT team mentor, I witnessed some of the challenges encountered by team members in trying to find housing for clients and in ensuring that their physical and mental health needs were being met. The weeks that I spent with the team during my practicum, combined with my previous years of experience as a street nurse, both motivated and informed the development of my research questions.

Outline of the Thesis

In Chapter 2, I provide a literature review that consists of three sections: 1) a review of reports and studies that provide a context for homelessness in BC; 2) issues related to housing clients with severe mental illness and/or addictions using the HF approach; and 3) the ACT model of community support and evidence of its effectiveness. In Chapter 3, I present the methodology for this study. I describe the recruitment of participants, the data collection and analysis, and the ethical considerations of this research. I also discuss the ontological and epistemological underpinnings of grounded theory research methodology.

The findings of this study are presented in Chapter 4, in which I explain the theoretical process by which ACT team members support their clients in maintaining housing. This process is organized into the following categories: Learning How, Developing a Therapeutic Relationship, Reinforcing Capacity, Enforcing, and Negotiating Re-Entry. In Chapter 5, I discuss how the findings of this study both align with and differ from those in the relevant literature. I discuss the strengths and limitations of the research, and I conclude by explaining how the grounded theory developed in this study contributes to the body of knowledge in this area.

Research Questions

The purpose of this study is to explore how the ACT teams support clients to remain housed within the current social environment, in which affordable housing is scarce, and the population served by the team experiences stigma and discrimination. The teams work with a heterogeneous population of clients in a context where housing programs nominally apply the approach of HF.

The literature on the specific work of ACT teams in providing housing support is sparse. Moreover, neither the type of support provided by ACT teams nor the extent of support is comprehensively discussed in the ACT literature. Providing clients with support to remain housed is only one aspect of the teams' work to stabilize clients and help them integrate into the community. Thus, the following research questions were formulated:

1. How do the participating BC ACT teams support their clients to maintain housing within the current social context?
2. What specific challenges do the ACT teams face in supporting their clients to maintain housing? How do they respond to these challenges, and what strategies do they use to address them?
3. How do the ACT teams balance the competing demands of the provision of therapeutic services with housing stabilization?
4. What factors promote and facilitate housing stability? What factors induce instability?

The participants in this study discussed both the successes and challenges they experienced as they worked with their clients to ensure they remained housed. The challenges and issues faced by the participants and their resolution and/or management of these challenges are encompassed in the grounded theory that was generated by this study. The following Chapter 2 presents the literature review.

Chapter Two: Literature Review

This chapter is organized in the following way. I review both the qualitative and quantitative literature on Housing First (HF) and Assertive Community Treatment (ACT). I then discuss the principles of the HF program and the attributes that have led to greater housing stability within the population. I next examine the role of the ACT teams in the HF initiative before discussing the attributes of the ACT model in greater depth and reviewing the literature on ACT teams and housing stability. I then review the research literature and reports on housing and homelessness in BC, which provides the background for the context in which the ACT teams work as well as insights into the experiences of the population served by the teams.

Housing First

As discussed in Chapter One, in HF programs, the provision of housing is not contingent on treatment for mental illness or substance use. The program's premise is that housing is a human right. Furthermore, HF holds that people should have autonomy in their housing decisions with regard to the type and location of housing and the extent to which they engage in treatment (Padgett, Gulcur, & Tsemberis, 2006; Tsemberis, 2010). The results of previous HF studies identified that program outcomes have inferred cost benefits to society. Consequently, this program has gained the attention of international policy makers, and HF has been implemented in various ways around the world (Pleace, 2012). The literature on HF indicates that the program has been credited with reducing the proportion of time that people spend being homeless (Gilmer, Manning, & Etten, 2009; Gulcur, Stefanic, Shinn, Tsemberis, & Fischer, 2003; Padgett, Stanhope, Henwood, & Stefancic, 2009; Tsemberis & Fischer, 2003). The program has also achieved housing stability among people who have experienced chronic homelessness, serious mental illness, and co-occurring substance-related disorders (Pearson, Montgomery, & Locke, 2009; Tsemberis & Eisenberg, 2000; Tsemberis, Gulcur, & Nakae, 2004; Tsai, Mares, & Rosenheck, 2010). HF has also been credited with inferred cost savings because once individuals are housed, their use of emergency room services is reduced (Perlman & Parvensky, 2006; Raine & Marcellin, 2007), and the frequency of their hospitalizations is decreased (Gilmer, Manning, & Ettner, 2009; Gulcur et al., 2003; Perlman & Parvensky, 2006). Moreover, involvement with the justice system and time spent in jails are reduced (Gilmer, Manning, & Ettner, 2009; Raine & Marcellin, 2007; Tsai et al., 2010; Padgett et al., 2006). Furthermore, substantial cost savings have been quantified (Gilmer, Manning, & Ettner, 2009; Gulcur et al., 2003). Thus, the evidence shows that HF has contributed to cost savings in many service areas and has resulted in the housing stability of formerly homeless individuals who live with mental illness.

As a model of service delivery, HF has been endorsed for a variety of socio-political reasons, including reducing recidivism in the criminal justice system and cost saving by reducing the use of police and health-care services. Although these arguments are compelling, they can detract policy makers and program developers from the most important humanitarian reasons for housing people: housing is a human right, and it allows recovery from homelessness (Pauly, Reist, & Schatman, 2011). To recover from homelessness and the associated poor health and psychological trauma, people need not only housing but also the ability to maintain their housing stability. Some clients with severe mental illness may require additional support to remain housed. Therefore, in order to promote housing stability effectively, both the capability to offer adequate individualised support that is external to and independent of the housing program and affordable housing are needed (Stefanic & Tsemberis, 2007). The provision of housing and support services are in turn dependent on the larger socioeconomic climate and the political will to provide affordable housing.

Housing First and Housing Stability

The Pathways to Housing First (PHF) program has been credited with providing stable housing for severely mentally ill clients directly from the street, thus proving that people with mental illness are capable of living in their own apartments when they are supported (Tsemberis & Eisenberg, 2000, p. 492). The success of this program challenges assumptions that such individuals must participate in psychiatric treatment or attain sobriety before being housed (Tsemberis, Gulcur, & Nakae, 2004). Previous research showed that participants who were housed and living independently in an apartment through the Pathways program had significantly greater housing stability compared to those who received housing contingent on treatment first. Offering housing without the requirement of treatment promotes both access to housing and housing stability by removing the barrier of compliance with treatment (Stefanic & Tsemberis, 2007; Tsemberis & Eisenberg, 2000; Tsemberis, Gulcur, & Nakae, 2004). This approach, which demonstrates that people with mental illness are capable, with appropriate support, of living in their own apartments, also challenges the presumed relationship between psychopathology and the ability to maintain housing (Tsemberis & Eisenberg, 2000, p. 492). The researchers used archival data obtained over a five-year period (1993–1997) to compare the housing retention rates of PHF tenants with those housed in programs requiring sobriety as a pre-requisite for housing. Of the PHF tenants, 88% remained housed compared to 47% of those in housing programs that required treatment and sobriety. Tsemberis and Eisenberg (2000) showed that clients labeled by other programs as “not housing ready” or “treatment resistant” are capable of choosing, obtaining, and maintaining independent housing (p. 492). Such negative labels are exclusionary and stigmatizing; moreover, they illustrate that the beliefs of both society and service providers must shift if the HF program is to be implemented successfully.

The finding that mentally-ill individuals are capable of retaining housing was reiterated in a rigorous randomized controlled study by Tsemberis, Gulcur, and Nakae (2004), which further refuted the need for individuals to participate in psychiatric treatment or to attain sobriety before being housed. The researchers compared the effectiveness of the PHF program to treatment-first programs in reducing psychiatric hospitalization and time spent homeless. The participants (n = 225) were recruited directly from the streets or upon discharge from hospital. All were homeless and lived with severe mental illness and/or co-occurring substance use. The participants were randomly assigned to either the PHF program or to a treatment-first program in which housing was contingent on sobriety. The follow-up survey at 24 months revealed that respondents in the PHF had been stably housed for 80% of the time on average, compared to the treatment-first group, which had been stably housed for 30% of the time. These results indicated a significant difference between the two groups. Furthermore, no significant difference was found in substance use between the two groups. Hence, the findings of Tsemberis et al. (2004) indicated that housing people without mandating treatment does not lead to an increase in substance use. Although the PHF program did not mandate treatment, the consumers were offered the support of the ACT teams. Both PHF housing services providers and the ACT teams took a HR approach in the provision of services, respecting and promoting consumer choice. The residential stability rate suggests that a person's psychiatric diagnosis is not related to his or her ability to maintain independent housing (Tsemberis et al., 2004).

A multisite (11 sites) observational study by Tsai, Mares, and Rosenheck (2010) concurred with the findings of Tsemberis et al. (2004). The researchers compared the housing outcomes of participants who were placed in HF programs (n = 578) to participants (n = 131) who received residential treatment before placement. The participants were not randomly assigned, making this trial less rigorous than a randomized controlled trial. The two groups were demographically similar. The findings showed that the HF group remained housed for statistically significantly more days than those who received treatment first, indicating that treatment did not correlate with remaining housed.

Stefanic and Tsemberis (2007) compared housing access and retention of people who used shelters by comparing participants assigned to the PHF program (n = 105) and those who were assigned to a control group who received treatment-as-usual services (n = 51). Participants who received treatment-as-usual services had to be willing to maintain sobriety, adhere to treatment, and adapt well to congregate residences (p. 266) where amenities are shared. A third group, the consortium group (n = 104), was assigned to various county housing agencies who provided HF services. The consortium HF was a group of agencies with no previous experience of HF. The services and types of housing were not described except to note that the housing was permanent and acceptance of treatment was not a prerequisite for access. The difference between the PHF and the consortium HF was discussed only in terms of experience with the HF program. The established PHF had greater understanding and experience with the program and its philosophies than did the consortium.

The findings of the study of the consortium and PHF programs showed that, over a four-year period, 78% of PHF program participants remained housed. Of the group who were housed via the consortium HF program, 68% retained their housing. Participants in the control group, who received treatment as usual, had not reached the endpoint of achieving permanent, independent housing (Stefanic & Tsemberis, 2007). Notably, the control group was difficult to monitor because of periods of homelessness and disconnection with services. Although the study performed a randomized control trial, the reliability of the results was weakened for a number of reasons, including missing data and the lack of follow-up data on the control group. In addition, the study did not test for differences between the control and the experimental groups at the onset of the study, so the reliability of the findings was reduced.

The researchers identified that the lower rate of housing retention for the clients of the Consortium agencies may reflect the challenges encountered by the service provider in the shift of services to a HF program (Stefanic & Tsemberis, 2007). The adoption of a HF philosophy requires that the service provider focus on the housing needs of the consumer instead of on their substance use or mental illness. Adherence to the HF philosophy also requires that service providers relinquish their power over the client by prioritizing the latter's needs and goals (Stefanic & Tsemberis, 2007) and respecting their choices. The difference in the outcomes of the PHF and HF could have been attributed to the barriers to initiating a HF program philosophy. Although the results of the study by Stefanic and Tsemberis (2007) were weakened by the lack of data on the control group, they concurred with the results of studies by Tsai, Mares, and Rosenheck (2010), Tsemberis and Eisenberg (2000), and Tsemberis et al. (2004).

Tsemberis et al.'s (2004) rigorous seminal study pioneered a shift toward a model of service that prioritizes housing instead of treatment, placing the lack of housing instead of mental illness and substance use at the centre of the homelessness issue. Tsemberis, the founder of the inaugural PHF program, pioneered this shift, not only in service provision (i.e., housing directly from the streets without the need for housing readiness) but also in continuing to advocate for a change in the attitudes of policy makers, service providers, and society toward believing that people with mental illness, who may or may not experience co-occurring substance use disorder, are capable of living independently in their own apartment with support, where acceptance of support is optional (Tsemberis & Eisenberg, 2000).

During my research for this study, through working with the regional ACT teams, I considered how this shift in service delivery was manifested in the provision of housing and the organization of services and in how these housing and support services are provided.

Tsemberis et al. (2004) and Pearson, Montgomery, Locke, and Buron (2007) identified that clients change residences within the HF program, and some clients do not remain housed. Although the concepts of housing stability and instability include the reasons for and the extent of movement within HF programs, the topic of housing instability has received scant attention in the PHF literature. There is, however, a discussion of housing instability in the PHF guide book (Tsemberis, 2010).

Tsemberis et al. (2004) observed that in the PHF program, as many as 30% of clients moved from the first place they were housed, some moved two or three times, and 16% of the total number of PHF participants did not remain housed. However, statistics on the movement of clients within the PHF program are not available in the PHF research literature. In the program, clients are rehoused if a conflict arises in their housing situation, or if they are at risk of housing loss, or cannot resolve issues that arise within their housing situation. This is referred to as rapid rehousing (Tsemberis, 2010) and is discussed in greater depth in the PHF guidebook. An infrastructure and a set of conditions are required to support the movement of clients within the program, including the ability to quickly re-house clients. Rapid re-housing is based on sufficient housing, a willingness of the agencies to re-house, the ability of the program to retain an apartment for 90 days (even if the client does not live in the apartment), and the ability to transport tenants and their belongings (Tsemberis, 2010). This infrastructure and these conditions are required to support the client’s ability to remain housed and would likely be necessary if a HF program, such as PHF, were to be established in the region studied here.

Pearson, Montgomery, Locke, and Buron (2007) studied the concept of housing stability in three HF programs. The researchers use the terms *stayers*, *intermittent stayers,* and *leavers* to describe the participants' (n = 80) housing tenure, which was tracked over 12 months. The *stayers* comprised 43% of the clients (n = 34); they remained in their housing and in the program for one year. *Intermittent stayers* comprised 41% of clients (n = 33). Despite leaving their housing during the one-year period and spending time in other environments, these clients remained in the HF program and were therefore considered stably housed. The *leavers* were clients who left the HF program during the one-year period; they represented 16% (n = 13) of the sample (Pearson et al., 2007, p. 17). No common characteristics of this group were identified or discussed by the researchers. Most *leavers* were categorized as "involuntary." The reasons for leaving included being asked to leave the program because of behaviour (not specified), institutionalization, and death (Pearson et al., 2007, p. 77).

According to HF program standards, 84% remained in the program for the year following program entry and could be classified as stably housed. These standards state that as long as clients stay in contact with the HF program manager and do not leave the program for more than 90 days, they are considered stably housed even if they do not live in their apartment during this period. I question the use of the term *stably housed* in this context because it is conflated with program engagement. The authors also used the term *stably housed* when referring to clients who moved two or three times. Given the flexible application of the term, the claim that 84% remained stably housed seems inaccurate and misrepresentative of the situation.

Although Pearson et al. (2007) asserted that the problem of homelessness was resolved by the HF program, for a minority of clients, issues arose that impeded their successful housing, which could result in loss of housing. In all three programs, the case managers reported disruptions caused by clients' behaviour relating to substance use or psychiatric decompensation (i.e., increasing symptoms of mental illness). Other behavioural issues included property damage, problem behaviour both related and unrelated to substance use, abusive conduct toward staff or other people in the building, and criminal activity. Problematic behaviour averaged one incident per month per person, which is not insignificant. The researchers pointed out that problem behaviour linked to alcohol or drug use, although uncommon within the HF setting, was serious enough to jeopardize the client's housing status. Approximately half (n = 40) of the total participants (n = 80) in this study were reported by case managers as using substances. However, only 20 per cent (n = 8) were considered to exhibit signs of severe impairment, therefore substance use was not necessarily problematic. It is noteworthy that this HF study is the only one in the literature to discuss housing issues and client instability. Successful housing does not come without challenges in working with factors that impede housing success and thereby promote housing stability.

Pearson et al. (2007) stated that they trained case managers to work closely with the researchers in data collection procedures, which supported consistency and accuracy in the data collection process. However, because of that study's problematic definition of being stably housed, its findings may have limited application. Furthermore, the number of participants was small, considering that the study covered three sites. In addition, the short period of one year may not have been long enough to establish outcomes of housing tenure. Nevertheless, the findings of this research study indicated what might happen in any HF program: some clients will retain housing, others may move before they settle, and substance use and behavioural issues may be factors in moving or losing housing. In the case of some clients, providing stable affordable housing does not guarantee housing stability; support is required to help some clients to remain housed. Pearson et al. (2007) did not comprehensively discuss the type or extent of housing support required, which is clearly an area that requires further research.

Pearson et al. (2007) stated that in the HF approach, achieving positive outcomes requires program policies and procedures that encourage working with clients and landlords to solve housing problems when they arise and that enable programs to retain units for clients who leave temporarily (p. 80). They also identified that maintaining housing stability requires a service approach that focuses on helping people keep their housing (p. 103). However, neither the program policies and procedures nor the service approaches are discussed in depth in Pearson et al. (2007).

Housing First and Choice

This factor was established as a tenet underpinning the HF program (Stefanic & Tsemberis, 2007; Tsemberis et al., 2004). It is an important element in both maintaining housing and promoting satisfaction in housing. Because there is a pronounced lack of affordable rental housing in British Columbia, I reviewed the available literature for studies on the teams' experiences concerning the degree to which client choice is and can be exercised, as well as the teams' perception and experience of the relationship between client choice and housing stability. Freedom of choice in housing has been linked to greater client satisfaction and housing stability than is achieved by approaches that mandate treatment (Greenwood, Schaefer-McDaniel, & Winkel, 2005; Padgett et al., 2009; Raine & Marcellin, 2007; Tsai et al., 2010; Tsemberis et al., 2004). Choice has also been linked to a possible reduction in psychiatric symptoms (Greenwood et al., 2005), as well as increased psychological well-being and quality of life (Tsai et al., 2010).

Tsemberis et al. (2004) measured the amount of perceived choice that participants had regarding housing location, neighbours, housemates, and visitors. In their randomised control trial, a designed and tested tool was used to measure the perceptions of choice in a large number of participants (n = 225) over a 24-month period. The perceptions of the HF group (experimental group, n = 99) were compared with those who were placed in housing contingent on treatment and sobriety (control group, n = 166). Participants in the HF group perceived their choices to be greater than those assigned to housing contingent upon treatment and sobriety. The HF participants had higher levels of control and autonomy in the program, which could have contributed to their success in maintaining housing (p. 665). The findings of this study by Tsembris et al. (2004) identified the need for consumer control, autonomy, and choice to be promoted by the housing program and individual service providers. These factors should be implemented at the levels of both the housing program and individual service provider.

The data obtained by Tsai et al. (2010) showed that having choice and higher levels of control in both housing and treatment lowered the participants' levels of psychiatric symptoms. Furthermore, a significant factor associated with choice was mastery, which is obtained by allowing people with mental illness to have increased control over the events in their lives. Greenwood et al. (2005) stated that even the most difficult consumers of mental health services can experience a reduction in symptoms by having a choice. Furthermore, they recommended the implementation of policies that increase, instead of reduce, consumer choice (p. 236).

The findings of the studies reviewed in this section (Greenwood et al., 2005; Tsemberis et al., 2004) can be considered reliable. Results were obtained from a large data set in randomised controlled trials. Established and pretested instruments were used to measure data. In particular, Greenwood et al.'s (2005) study added to the knowledge about consumer choice and reinforced the need for consumer choice to be facilitated and respected in the implementation and planning of care, both of which would require a shift in the approach to service delivery. The researchers examined the association between consumer choices in several areas, such as treatment, living environment, case management, and housing outcomes. Choice of living environment was independently predictive of psychological well-being and subjective quality of life. Choice was not associated with superior housing outcomes (p. 1674).

The findings of the studies reviewed here indicate that housing and housing support programs need to facilitate client choice, autonomy, and self-mastery in order to reduce psychiatric symptoms and promote psychological well-being. Also needed are policies that promote the client's choice in attaining housing (Greenwood et al., 2005; Tsai, Mares, & Rossenheck, 2010). Actualizing choice requires that practitioners shift away from the traditional treatment model of support.

Housing First and Reduced Service Costs

HF has been shown to reduce costs in both health care and the criminal justice system. Gilmer, Manning, and Ettner (2009) identified that, once housed, the participants' use of in-patient emergency services and the criminal justice system were reduced. Perlman and Parvensky (2006) found that when housed participants significantly reduced their use of emergency room services, in-patient hospital stays, use of detox beds, and incarceration were also reduced. Raine and Marcellin's (2007) findings concurred with those of previous studies, identifying that housed people had a dramatic reduction in the amount of jail time and the use of emergency services.

Gilmer, Manning, and Ettner (2009) collected data from a county's mental health-service information system (MIS) and conducted a comprehensive cost analysis of three HF programs. Their analysis encompassed the utilization costs of case management, outpatient, inpatient, emergency, and criminal justice system services for 177 clients during the two years prior to their participation in the Reaching Out and Engaging to Achieve Consumer Health (REACH) program and during two years post-intervention. The REACH HF program used a variety of housing options, not only individual rental apartments at scattered sites as in the PHF. The mixed housing offered by REACH and the client population served closely aligns with the type of housing provided in the region of my study.

The REACH study used a control group with demographics (n =166) similar to the study group, and therefore the results were comparable. Post HF intervention costs showed a decrease in hospitalization and inpatient service costs, but a significant increase in case management costs and a decrease in criminal justice system costs. Cost savings in other service areas offset the increased cost of community service provision.

These results concurred with a previous study conducted by Perlman and Parvensky (2006). Their pre- and post-housing study documented reductions in the participants' (n = 19) use of emergency room services, in-patient hospital stays, use of detox beds, and incarceration. The data included four years of medical, substance use, treatment, and legal records of participants who had been housed in the HF program for at least two years. The results showed the following decreases: in-patient stays by 66%, emergency room use by 73%, detox use by 82%, and incarceration by 76%. The limitation of this study was its small sample size. However, because Perlman and Parvensky's (2006) study utilized both self-reports and participant records, the corroborated data provided an accurate account of the participants' pre- and post-housing uses of services.

Raine and Marcellin (2007) surveyed 88 formerly homeless individuals housed through the City of Toronto's Streets to Homes program, which is part of that city's HF initiative. Researchers relied on participants' self-reports regarding their history of homelessness, use of emergency services pre- and post-housing, as well as changes in behaviours, such as alcohol and other drug use (p. 7). The analysis of the participants' self-reports of pre- and post-housing experiences demonstrated that after individuals were housed, there was a dramatic decrease in their use of emergency services (e.g., police detox or the "drunk tank") and a significant reduction in arrests and jail time. Although based on self-reports, the results were similar to those of previous studies in terms of reductions in the use of health care and criminal justice services.

The studies reviewed here demonstrated that HF is associated with a decline in both service use and actual costs. The present qualitative research study explores how support is provided to maintain housing and promote the client's health, and investigates how the ACT teams work with the police and the judiciary within the region's court system.

Summary of Housing First

The results of the review of the relevant literature indicate that people who live with mental illness, who may or may not experience co-occurring substance use disorder, are capable of living independently in their own apartment with support (Tsemberis & Eisenberg, 2000). Moreover, they do not require psychiatric treatment or sobriety before being housed. Furthermore, consumer choice and control were shown to support the housing stability of clients (Greenwood et al., 2005; Tsai, Mares, & Rossenheck, 2010). Affordable housing and policies that promote the client's choice in attaining housing are needed (Greenwood et al., 2005; Tsai, Mares, & Rossenheck, 2010). Actualizing choice requires that practitioners shift away from the traditional treatment model of support. This shift will need to manifest at both system and provider levels.

ACT teams provide support to people who live with mental illness in the community. Based on the HF initiative, in the case of the region where this research study was conducted, the teams support many clients to remain housed. The regional ACT program is separate from the HF program. I now explain the relationship between the studied regional ACT teams and the Housing First program, discuss the literature concerning the attributes of the ACT model in greater depth, and review the literature on ACT and housing.

Assertive Community Treatment

Assertive community treatment (ACT) teams, as discussed in the ACT literature, provide community support for clients with severe mental illness, who are often frequent users of inpatient psychiatric services. The teams focus on clients who are the most difficult to engage. The model is designed such that services are provided by a team of professionals and are not brokered to other agencies. The teams work with clients and help them deal with issues as they arise in their lives (Phillips et al., 2001). In the PHF program, the ACT teams provide support to their clients to maintain housing (Tsemberis, 2010; Tsemberis et al., 2004). ACT teams support clients housed through HF initiatives in many American states (Neumiller et al., 2009; Pearson et al., 2008) and have become an integral part of Canada's HF framework (Gaetz, Scott, & Gulliver, 2013).

The regional ACT teams investigated in this research work with their clients in the context of the HF program as part of the region's initiative to break the cycle of homelessness (Government of BC, 2008). Housing providers and housing agency staff claim to use a HF approach, and they refer clients who require support to the regional ACT teams (Regional Document, 2012). Although the work of the ACT teams has been identified as part of an overall approach to promote housing stability (Tsemberis, 2010; Pearson et al., 2008) and ACT teams have been identified as one of the client support programs offered to people with severe mental illness in the HF context (Pearson et al., 2008; Neumiller et al., 2009; Tsemberis, 2010; Tsemberis et al., 2004), the specific work of ACT teams in supporting clients to maintain housing is not clearly or comprehensively discussed in the research literature.

In this thesis, I identify the services and treatment modalities provided by the participating ACT teams to clients who experience social and health issues related to substance use, with or without mental illness, as they relate to supporting clients to remain housed. In the next section of the literature review, I provide a synopsis of the evidence for the use of the ACT model and the population served, describe the ACT team structure and the critical components of the ACT program model, review and critique previous studies on ACT and the provision of housing support and the reduction of homelessness, and focus on evidence that shows the ACT teams' provision of support to clients with severe mental illness and co-occurring substance use.

Synopsis of the Literature on ACT

The ACT model has been widely tested and is considered to provide superior, cost-effective care for people with severe mental illness. The ACT model has been utilized in BC because experts consider it best practice in supporting mentally ill individuals to adjust to life in the community (Drake et al., 2001; Krupa et al., 2005; McGrew & Bond, 1995; Nelson, Aubry, & Lafrance, 2007; Phillips et al., 2001; Tsemberis & Salyers, 2003). Several reviews in the Cochrane database have supported the effectiveness of ACT in the community care of the homeless population (Coldwell & Bender, 2007, 2010; Deitrich, Irving, & Marshal, 2010; Marshall & Lockwood, 1998) because of its efficacy in reducing homelessness and improving psychiatric symptoms and hospitalization outcomes. ACT is the most widely tested model of community care for persons with severe mental illness (Burns & Santos, 1995; Marshall et al., 1998). It has been credited with reducing the frequency of hospitalization (Colwell & Bender, 2007; Ziguras & Stuart, 2000; Nelson et al.,

2007) and the length of hospital stays (Marshall & Lockwood, 1998) of severely mentally ill clients who are supported by the teams. Previous reviews of the literature showed that the implementation of the ACT program to support clients with severe mental illness reduces hospitalization and homelessness.

The efficacy of ACT in reducing hospital stays has been empirically confirmed. ACT is also credited with being effective in reducing the financial cost of inpatient services (Bond, Miller, Krumweid, & Ward, 1988; Bond, McGrew, & Fekete, 1995; Bond et al., 1990; Burns & Santos, 1995; Bush, Langford, Rosen, & Gott, 1990; Borland, McRae, & Lycan, 1989; Dincin et al., 1993; Coldwell & Bender, 2007; Nelson, Aubry, & Lafrance, 2007; Quinlaven et al., 1995; Rosenheck et al., 1995). Consequently, the ACT model has been supported widely by policy makers in the provision of community mental health outreach services to people with severe mental illness. The success of the ACT program has been attributed to the components of the program model. In the context of the regional ACT teams, I review these components and explore how they contribute to the effective support of clients to remain housed. The following section provides a brief overview of the ACT program model.

The ACT Program Model

ACT teams require extensive skills, knowledge, and competencies to provide support services to meet the complex needs of homeless people with mental illness and substance abuse issues. Team members also need to hold values and beliefs that facilitate supportive care (Coursey et al., 2000). Teams are composed of members in different disciplines having diverse cultural and philosophical outlooks (Garland, Harrison, & Schwartz, 2007). In theory, this diversity of knowledge and expertise within the multidisciplinary team ensures that “the team has the competencies to respond holistically” to the clients’ needs (Williams, Kukla, Bond, McKasson, & Slayers, 2009, p. 222). Since the principles of ACT demand that the whole team supports the client, the team members, despite their different disciplinary and philosophical backgrounds, must work together to provide supportive services. However, because there is limited evidence that the theoretical view of a multidisciplinary ACT team is successful in practice, my objective in the present thesis is to identify the strengths of multidisciplinary teams in order to determine whether in fact their combined professional skills and overall teamwork do help reduce homelessness and promote housing stability.

The distinguishing features of the ACT model are the following: 1) the team's assertive engagement with clients, seeing clients daily if needed; 2) the locus of the program is in the community and in the provision of outreach services; and 3) small client-staff ratios (Bond, Drake, & Meuser, 2001; Burns & Firn, 2002; Coldwell & Bender, 2007; Drake et al., 2000; Latimer, 2001; Lenham, Dixon, DeForge, & Postrado, 1997; McGrew & Bond, 1995; McGrew, Bond, Dietzen, & Slayers, 1994; McHugo, Drake, Teague, & Xie, 1999; Phillips et al., 2001; Santos, 1993; Test, 1992; Test & Stein, 1976). Other significant features of the program model are that the multidisciplinary team is the core service provider for the client, and the whole team works to help clients meet their needs. ACT services are not brokered; that is, clients are not referred to outside resources for mental health or rehabilitative services (McGrew et. al., 1994; McHugo et. al., 1999; Santos, 1993; Test, 1992; Test & Stein, 1976). Each team has a psychiatrist (full- or part-time), and the team provides a 24-hour service (Bond et al., 2001; McGrew & Bond, 1995; McGrew et al., 1994). Phillips et al. (2001) noted that the services provided by the team are individualized, comprehensive, and flexible, with no time limit imposed on the client's ability to receive such services. The regional ACT teams that participated in my research study provide services to a diverse population.

Because ACT services are not brokered, and clients are not referred to outside resources for mental health or rehabilitative service, I explored the extent to which these teams could be self-contained and independent in their provision of housing support and rehabilitative services for mental health and substance use. The participating regional ACT teams work with a diverse population of individuals who have a history of chronic homelessness. This population includes people whose primary diagnosis is not axis one and people who live with a spectrum of disabilities related to substance use. This clients are different from the population that the ACT programs were originally designed to support, that is, clients who have axis one disorders who may or may not use substances concurrently. I investigated whether the teams are self-contained in their provision of a range of substance-use services. Because the studied regional teams work within the context of HF, can their program be self-contained in supporting to clients to remain housed?

The participating BC ACT teams are guided by the BC Program Standards for ACT Teams (van der Leer, Musgrave, Somers, Samra, & Queree, 2009), which reflects all the components previously emphasized in the literature. Fidelity scales and guidelines provide benchmarks for best practice and feedback on program development. The fidelity standards focus largely on team composition and measurement, such as contact with clients in the community instead of the office and the full responsibility of the team for the provision of treatment and services. The fidelity standards also include the measurement of the clinical outcomes of clients, such as symptom reduction, social integration, and housing retention. The fidelity scale, on the other hand, concerns the structure and functioning of the team itself. The participating ACT teams reported using some fidelity benchmarks to evaluate their program. The staffing composition of ACT teams differs in terms of the primacy of psychiatry and nursing staff (McGrew & Bond, 1995) and the extent to which specialists in vocational training or substance use are employed. The distribution of caseloads also varies between teams, depending on the specialized focus of the team (McGrew & Bond, 1995; Phillips et al., 2001).

However, the literature review did not yield previous studies on the preferred staffing composition of an ACT team that focuses on providing services to a population with a history of chronic homelessness, severe mental illness, dual diagnoses, addictions, and involvement in the criminal justice system. The present study on the work of regional ACT teams helps fill this gap in the research. The ACT teams provide assertive outreach that aims to maintain client engagement and provides a range of effective interventions and treatments that improve client outcomes. Because the provision of service is labour intensive, caseloads are small (Firn & Burns, 2007).

Previous studies have shown that positive client outcomes can be achieved in clients with mental illness and concurrent substance use if there is strong adherence to the ACT model (Dates et al., 2009; Meisler et al., 1997; Teague et al., 1995; Tsemberis et al., 2004). Fidelity scales, such as the 26-item Dartmouth Assertive Community Treatment Scale (DACTS), have been developed to measure the ACT teams' adherence to the program model (Teague, Bond, & Drake, 1998). It is interesting to note that the criteria of fidelity scoring for DACTS was not designed to measure the work of ACT teams supporting homeless people with dual diagnoses. Furthermore, the literature that was used to develop the points used in the scoring system did not focus on that population (Matejkowski & Draine, 2009). The measures are both quantitative and qualitative and provide a guide to program implementation and evaluation, specifically as they relate to the structure of the ACT program, such as team composition. Measuring a team's fidelity to ACT criteria is fundamental in research intended to establish the effectiveness of the outcomes of ACT teams.

However, the evaluation of ACT fidelity is beyond the scope of this research study and the ability of this researcher and therefore is not discussed in the thesis. Instead, this research study identifies the combined skills of the team and the structure of the program that are beneficial in supporting clients to remain housed.

ACT and Housing Support

Very few research studies have specifically explored the ACT team's role in supporting clients in housing. The literature on HF mentions that ACT provides clinical support to clients (Montgomery & Locke, 2009; Stanhope & Padgett, 2010; Tsemberis & Eisenberg, 2000; Tsemberis et al., 2004) and works with clients as they navigate living in the community (Henwood, Stanhope, & Padgett, 2011). The research of ACT and housing has often compared the effectiveness of the ACT model with the provision of intensive case management in supporting clients to remain housed (Coldwell & Bender, 2007; Nelson & Lafrance, 2007). However, no studies have specifically addressed the attributes of the model or whether they facilitate the team's ability to support clients to maintain housing.

Matejkowski and Draine (2009) studied the extent to which an ACT team was able to adhere to the ACT fidelity standards when it worked within the context of the HF program. The researchers measured adherence to and deviations from fidelity standards using the 26-point DACTS scale. Data were collected through questionnaires and chart reviews of notes related to housing support. Because the consumers of HF could choose whether or not to interact with the ACT team, the face-to-face contact of team members with clients was only 50%, which resulted in a low fidelity score, and hospitalization rates were higher than most ACT teams adhering to DACT standards. The higher rate of hospitalizations was because the clients contacted the team only when they were in crisis.

The team had a low fidelity score for their work with informal support resources, such as property owners. The researchers (Matejkowski & Draine, 2009) believed that this was because property managers limited their contact with this client population, and the clients had "burnt their bridges" with other services, which accounted for the ACT team's reduced interaction with those services. This thesis, in part, explores the participants' perceptions of the working relationship between the regional ACT team and HF program staff and some of the philosophical differences between the two programs in the regional context.

In adhering to the principles of HF, the teams in the Matejkowski and Draine (2009) study were not assertive in their client engagement. Once referred to the team, the client could choose whether to engage with the team and, if so, how often. The high rate of hospitalization raised the concern that the clients' reduced engagement with the ACT teams was detrimental to their overall health (Matejkowski & Draine, 2009). The researchers also found that ACT staff reported spending a large portion of their working day assisting clients in the upkeep of their housing and in the challenging task of helping the client maintain residential stability. This concern was also identified by Pearson, Montgomery, and Locke (2009) and Stanhope and Padgett (2010), who found that when chronically homeless clients were housed directly from the street, the ACT team members' engagement in housing their clients left less time to work with the client to establish and reach treatment goals and work toward recovery.

ACT and Reducing Homelessness

Coldwell and Bender (2007) conducted a review of seven studies that measured the homelessness outcomes of ACT clients. Each study demonstrated a reduction in the time spent homeless and identified ACT as having a positive effect on reducing homelessness. Kreindler and Coodin (2010) conducted an observational study to examine the housing histories of ACT clients (n = 65) with severe, persistent mental illness. Secondary data was collected from medical records spanning two years pre-admission to the team and up to four years after intake. The researchers examined the pre- and post-ACT changes in residential tenure and independent living. After six months in ACT, the client population demonstrated a sustained and significant improvement in housing stability and in the number of clients who were able to live independently. This success was attributed to the availability of housing stipends to cover rent, the ACT team's ability to support their clients, and the availability of quality independent housing. The researchers concluded that ACT increased housing stability over the long term. A key factor was the quality of independent living, which depends on the availability of affordable rental housing. However, although ACT team support was noted in the Kreindler and Coodin (2010) study, the extent and type of support and the specific contribution to housing stability were not addressed.

Kreindler and Coodin (2010) also found that clients who used substances continued to face challenges and that substance use was strongly linked to shorter housing tenure. The results of their study indicate that specific factors increase the housing stability of clients, such as independent housing, income and the availability of rental supplements, and the support of the ACT team. When these factors were in place, the client's ability to retain their housing and live independently increased. On the other hand, some factors could be destabilizing, including substance use (Kreindler & Coodin, 2010). A subgroup of clients might need to be offered targeted supportive strategies to retain their housing (Kreindler & Coodin, 2010). Generally, supportive housing strategies for this population are not clearly discussed in the ACT literature.

ACT Teams Supporting Clients with Co-Occurring Substance Use

Rosen, Mueser, and Teeson (2007) explained that the ACT model was designed and works best for clients with debilitating and severe mental illness. The model was designed more than 30 years ago (Stein & Test, 1980), and in many places, the demographic supported by ACT has changed. ACT teams have been adapted to work with special populations, such as people who are diagnosed with substance use (Drake et al., 1998; Neumiller et al., 2009; Phillips et al., 2001), and/or chronic homelessness (Lenham et al., 1997; Neumiller et al., 2009). ACT program standards have not been developed to measure the outcomes of an ACT team's integrated work with a demographic that has a history of chronic homelessness and substance use (Neumiller et al., 2009).

ACT teams differ in their approaches to working with clients who use substances. Some ACT teams provide substance use counseling, but there are few studies on the efficacy of this approach (Drake, O'Neal, & Wallach, 2008; Fletcher, Cunningham, Calsyn, and Klinkenberg, 2008; Fries, 2011). There is limited and conflicting data on the efficacy and superior benefits of ACT in delivering treatment to clients with substance use disorder, compared to case management approaches (Drake et al., 1998). ACT teams have a tendency to focus on treatment and abstinence (Fries, 2011). This focus is problematic as individuals engage in a spectrum of substance use, and therefore a spectrum of support is required, which includes harm reduction (Goldner et al., 2004). ACT has been reported weak in treating clients with a history of substance use (Bond et al., 2000; Essock et al., 2006).

Bond et al. (2000) reviewed 25 randomized control trials that quantified the outcomes for ACT clients in several areas, such as hospitalization, housing stability, and substance use. They concluded that although ACT had a positive impact on the housing of clients and their engagement with the team, it had a weak impact on substance misuse and social functioning. Essock et al. (2006) conducted a clinical trial over a three-year period in which participants (n = 198) were randomly assigned to either integrated dual-diagnosis treatment for substance abuse delivered as part of an ACT model or treatment that was part of the standard case management model (CM). The CM team case managers had twice as many clients as the ACT team did. Participants in both the CM and ACT groups decreased their drug and alcohol use over time. The outcomes of substance use were measured using urine toxicology tests and saliva tests for alcohol, addiction severity index (ASI), and alcohol and drug evaluation tools. A timeline follow-back calendar was used to measure alcohol and drug use. The comparison of patterns of substance use in both groups demonstrated a decrease in substance use by the end of the study period. However, the effects of ACT on substance abuse were small. The use of a decrease in substance use as an outcome measurement is indicative of the ACT team's focus on treatment and abstinence instead of harm reduction (HR).

Fletcher et al. (2008) evaluated the effectiveness of the three approaches used in treating clients with co-occurring mental illness and substance use: Integrated Assertive Community Treatment, (IACT), Traditional Assertive Community Treatment Only (ACTO), and standard case management (SCM). The participants (n = 191) were followed for 30 months. The integrated ACT team provided substance use counseling and treatment. A specialist was part of the team, which integrated substance use treatment and counseling as part of their service. The ACT-only team did not have a substance use counsellor or a substance use treatment service. The IACT staff provided substance abuse counseling by a substance abuse specialist in bi-weekly treatment groups. The ACTO clinicians referred clients to community substance abuse treatment providers. The participants assigned to SCM were given a list of substance abuse treatment providers and helped to make initial contact with the agency. The participants in all three groups had a reduction in psychiatric symptoms and reduced their substance use. IACT patients maintained their improvement for an additional nine months longer than the patients assigned to ACTO did. Fletcher et al. (2010) attributed the success to the integration of substance-use treatment into the program.

Drake et al. (1998) compared two programs that provided integrated mental health and substance use treatment: ACT and SCM. Drug and alcohol use was assessed according to a rating scale through clinical observation, client self-report, and clinician ratings. The study was carried out for more than three years with 223 participants living with co-occurring mental illness and substance use. The data analyses sub-divided the participants in the two programs into those who were assigned treatment and those who were exposed to treatment during the study. In line with previous studies, the findings showed that participants in all groups substantially reduced their substance use over time. There was no significant difference in recovery from alcohol use in either group. The ACT participants exposed to treatment reported fewer days of alcohol use than those assigned to SCM did.

There is a significant gap in the research regarding how ACT teams support clients in the community to remain housed. The type and extent of support has not been comprehensively discussed, even though ACT teams throughout the USA and increasingly in Canada, work within a HF context. ACT reportedly has a weak impact on treating clients with a history of substance use (Bond et al., 2000; Essock et al., 2006). There is also a significant gap in the research regarding how ACT teams support clients in the community to remain housed. The type and extent of support has not been comprehensively discussed. The research on ACT teams' work in the context of HF is scant and points to the need for ACT to adjust its practice in this context (Neumiller et al., 2009; Tsemberis, 2010).

Housing and Homelessness in BC

Factors Leading to Homelessness

The regional ACT teams studied in this thesis support clients with severe mental illness who are highly vulnerable to homelessness or housing loss. ACT clients are directly affected by an intersection of structural, social, and individual factors (Echenberg & Jensen, 2009) that make it difficult to access and maintain housing, which increases their vulnerability to homelessness.

The structural factors that contribute to homelessness include poverty (Klein et al., 2008), an inadequate social safety net (Wallace, Klein, & Reitsma-Street, 2006), and de-housing policies (Gaetz, 2010). De-housing policies led to the dismantling of Canada's national housing strategy by reducing spending on affordable and social housing, including co-op housing, and the development of "housing policies to favour home ownership" (Gaetz, 2010, p. 22). As described by Gaetz, these de-housing policies have led to a lack of affordable housing and the privatization of the housing market (Gaetz, 2010; Klein, 2009; Patterson, 2007; Shapcott, 2009). The social factor of stigma is a barrier to attaining housing for people who experience mental health issues (Corrigan, 1998; Forchuk et al., 2007). Other factors that can contribute to homelessness include mental illness and/or substance use (Fazel et al., 2008). The co-occurrence of mental illness and substance use increases an individual's vulnerability to homelessness and to remaining homeless (Drake, Osher, & Wallach, 1991). Conversely, mental illness and substance use can be exacerbated by homelessness (Hwang, 2001). In this study, I explore how the ACT teams negotiate the factors that are barriers to supporting their clients to remain housed. The following sections discuss these factors as they relate to homelessness and the poor health of this population.

Poverty and the inadequate social safety net. Poverty is the predominant factor in homelessness. Although BC is a rich society, it has the highest poverty rate in Canada: 13% of the total population in this province lives in poverty. Poverty is measured according to Statistics Canada's Low Income Cut-Off lines (LICO) and is defined as the income level at which a family may be in straitened circumstances because it has to spend almost all of its income on basic items (i.e., food, clothing, and shelter) than does the average family of a similar size (Statistics Canada, 2012). Over the past two decades, poverty has continued to increase because of several factors, such as low minimum wages, inadequate income assistance rates, and a declining labour market. Consequently, the number of homeless people continues to increase (Klein et al., 2008). Many ACT clients receive income assistance. However, not only are income assistance rates inadequate but also the assistance itself is difficult to access. A mixed methods study by Wallace, Klein, and Reitsma-Street (2006) demonstrated that employment and income assistance for welfare recipients in BC is difficult to access because of the complex application process, new eligibility rules, a decrease in the supply of both advocates and case workers, and the loss of face-to-face services. Wallace et al. (2006) determined that, over a three-year period from 2001 to 2004, the new welfare eligibility rules contributed to a sharp increase in homelessness in both Vancouver and Victoria. An increasing number of people (from 50% to 75% in the period) experiencing homelessness in these two cities reported that they were not receiving welfare.

Welfare benefits, as well as being difficult to access, do not cover the cost of living, shelter, and basic necessities, such as food, clothing, and transportation (Klein et al., 2008; Atkey & Siggner, 2008). This means that people require emergency assistance in obtaining food and shelter (Wallace et al., 2006). People living with a disability (e.g., people with severe mental illness or co-occurring mental illness and substance use), despite receiving Enhanced Medical Services Coverage and disability benefits, also report living in poverty. A qualitative study conducted by Condon and Newton (2007) reported that, in order to make it through the month, people with disabilities described compromising on food by skipping meals or buying low-quality food, and they were unable to afford treatments, such as therapy or vitamins, which might have maintained their health.

Klein and Pulkingham (2008) conducted a survey of a small sample of 62 welfare recipients in three BC cities over a two-year period. They concluded that living on welfare means living in poverty: daily life is fraught with desperation, poor health, and the need to survive. To meet their basic needs, people depend on charity, food kitchens, community services, and the emergency acute care health system. With these limited options, in order to survive, a few welfare recipients were compelled to turn to survival sex, panhandling (Klein & Pulkingham, 2008), and binning. In order to make ends meet, one quarter of the study's participants engaged in crimes of poverty, such as selling drugs or stealing. As a society, we judge people with respect to the choices they make in their lives, giving little or no consideration to the poor range of options available to some individuals: "[the] myth of choice asserts that homeless people are homeless only because they make bad choices" (Allison, 2007, p. 254). As previously discussed, poverty and Canada's de-housing policies have contributed to homelessness and the reduction of options in people's lives. Cutbacks in government housing programs have resulted in a lack of affordable rental housing and long waiting lists for social housing.

In BC, almost no new social housing has been built since the 1990s. Although there has been an increase in market rental apartments, many people cannot afford them because of inadequate wages and the increasing cost of rent (Pauly, Cross, Valance, Wynn-Williams, & Stiles, 2013). Average market rents throughout BC and in Metro Vancouver rose significantly between 2007 and 2011, with a 14% increase in the rental cost of a bachelor apartment and a 13.6% increase in the cost of a one-bedroom apartment (Canadian Mortgage and Housing Corporation, 2012). Housing costs continue to increase without a corresponding increase in shelter assistance for people with disabilities (Disability Without Poverty Network, 2012, pp. 4–5).

The BC Ministry of Housing and Social Development (2008) reported that individuals on income assistance receive up to $375 per month, while a four-person family receives a maximum of $700 per month. The Disability without Poverty Network (2012) reported that amounts have remained unchanged in BC over the last decade (2001–2010), despite the increase in the basic costs of food, clothing, and shelter. People on income assistance cannot afford to pay market rental rates for housing. In both Victoria and

Vancouver, for example, the monthly rents of bachelor and one-bedroom apartments are, on average, twice the amount of a single individual's monthly income assistance. Furthermore, landlords are often reluctant to rent to people with mental illness (Echenberg & Jensen, 2009).

Stigma. An Ipsos Reid survey conducted on behalf of the Canadian Medical Association (2008) showed that 46% of Canadians believed that "mental illness" is used as an excuse for bad behaviour, and almost 30% feared people with a mental illness. Indeed, fear leads to the social exclusion and stigma of people who experience mental illness (Clarke & Row, 2006; Substance Use and Mental Health Services Administration [SAMHSA], 2010). Many myths about mental illness lead to the oppression of people who live with these illnesses, and these publicly held misconceptions create barriers to being housed and accessing support. Therefore, stigma reduces the quality of life of people living with mental illness (Csiernik, Forchuk, Speechless, & Ward-Griffin, 2007). The Kirby Commission report, *Out of the Shadows at Last* (2006) found that people with severe mental illness faced stigma in all aspects of their lives and had great difficulty in gaining access to adequate health care and safe, affordable housing. The Commission noted that 27% of people with severe mental illness required affordable housing and did not reside in adequate housing (Government of Canada, 2006). People affected by poverty and homelessness often carry the heaviest burden of stigma in society as a result of these factors (Strike, Myers, & Millson, 2004; Takahashi, 1997).

Substance use is also highly stigmatizing. People who use substances also experience marginalization, and they are exposed to social exclusion, ostracism (Room, 2005), devaluation, alienation (Ahern, Stuber, & Galea, 2007), and criminalization. Thus, individuals living with mental illness, poverty, and/or substance use experience multiple, intersecting stigmas. I now explain what I mean by intersecting stigmas.

People who are poor, impoverished, and therefore of low socioeconomic status live with the oppression generated by societal attitudes toward them. Additionally, they are discriminated against because they live with mental illness and/or the negative physical effects of substance use. Consequently, they also experience social prejudice and oppression because of their disability. The oppression is experienced at the individual level; however, as discussed in the Chapter One, social policies, such as those governing welfare rates, housing stock, and housing affordability, are systemic and structural forms of this oppression, which lead to the lack of social support for an affected individual. Judgmental societal attitudes toward mental illness and substance use lead to the discrimination and rejection of mentally ill individuals by relatives, friends, and employers (WHO, 2001). Estrangement from family and friends increases the risk of poverty and homelessness, sometimes robbing people of opportunities for safe housing (Corrigan & Watson, 2002).

Mental illness and homelessness. Housing is crucial to recovery from mental illness, yet mental illness is a factor that increases the risk of a person becoming homeless (Frankish, Hwang, & Quantz, 2005; Mental Health Policy Research Group, 1997; Patterson, 2007; Sullivan, Burnam, & Koegal, 2000). Moreover, the prevalence of mental illness is higher in the homeless population than in the general population (Acorn, 1993; D’Amore, Hung, Chiang, & Goldfrank, 2001; Fazel, Khosla, Doll, & Geddes, 2008; Folsom & Jeste, 2008; Goering, Tolomiczenko, Sheldon, Boydell, & Wasylenki, 2002). Because of the cyclical and long-term nature of most mental illnesses, some people with severe mental illness have difficulty getting and keeping employment (Drake, Wallach, Teague, Freeman, Paskus, & Clark, 1991; Patterson, 2007). Some may experience episodic mental illness, which increases their dependence on government-funded benefits and assistance programs. As discussed above, not only are income assistance rates inadequate but assistance can be difficult to access.

Homelessness that is caused by poverty is both visible and invisible. The person sleeping on cardboard in the shop doorway is visibly homeless but the homelessness of many people in our communities is less visible. In the literature, homelessness is referred to by various terms, such as absolute homelessness, rootlessness, hidden homelessness, houselessness, and being inadequately housed.

People who are absolutely homeless live on the street (Condon & Newton, 2007; Echenberg & Jensen, 2008; Hwang, 2001; Power, 2008) or in places not intended for human habitation (Canadian Homeless Research Network, 2012). The Canadian Homeless Research Network (2012) defines this brutal living situation of being homeless as *unsheltered*. People who stay in any type of shelter are described as *emergency sheltered*.

People whose plight is less visible are *provisionally accommodated*. These include individuals and families who do not have the security of their own home and do not have a permanent address. They live in their cars or in other households with friends, neighbours, or relatives in a pattern often referred to as “couch surfing” (Eberle, Kraus, & Serge, 2009; Condon & Newton, 2007; Power, 2008). Their situation is defined by Girard (2006) as “houselessness” (p. 104). The true extent to which homelessness is experienced by individuals and families is unknown because of the large number of people who are provisionally accommodated. Another group is insecurely housed; that is, their housing is precarious because of economic insecurity or is substandard in terms of health and safety (Canadian Homeless Research Network, 2012).

Substance use, mental illness, and homelessness. It is estimated that approximately 39,000 adults in BC have a severe addiction and/or mental illness (SAMI) and are inadequately (*insecurely*) housed. Of that number, perhaps 11,750 are absolutely homeless, and 26,500 are imminently at risk of homelessness because of inadequate housing and support (Patterson et al., 2007). Substance use has been described as the most common comorbid complication among people with severe mental illness (Drake et al., 2001; Drake, Mueser, & Brunette, 2007; Reiger, Farmer, & Rea, 1990). Substance abuse is diagnosed when a person's use of a substance continues even when their situation is dangerous or the person develops a medical condition related to substance misuse. Another strong indicator of substance misuse is that its use persistently interferes with social relationships and the ability to function. Fazel et al. (2008) determined that people who experience severe mental illness with co-occurring substance use are disproportionately represented within the homeless population. This is consistent with other findings from comparisons with the general public. Canada’s homeless population has a high prevalence of mental illness and substance use (Canadian Institute for Health Information, 2007; Canadian Mental Health Association, 2003; Goering et al., 2002). They also experience poverty and barriers to accessing housing (Pauly et al., 2013).

The risk of substance use leading to addiction is greater for individuals who have encountered stressful life experiences. There is a strong and complex relationship between stressful or traumatic events and substance use problems (Khoury, Tang, Bradley, Cubells, & Ressler, 2010; Maté, 2008). Because homelessness and severe mental illness are both stressful and traumatic, they can be mutually intensifying, and they may be experienced as a result of past traumatic events or ongoing trauma. A complicating issue is that people who are homeless are at “very high risk for substance abuse” irrespective of mental illness (Sullivan, Burnam, & Koegal, 2000, p. 446).

Homelessness and health. Being homeless severely compromises a person's physical and mental health (Frankish, Hwang, & Quantz, 2005; Hwang, 2001; Johnson & Chamberlain, 2011; Patterson, 2007; Public Health Agency of Canada, 2006) as well as their personal safety (Fazel, Khosla, Doll, & Geddes, 2008; Hwang, 2010; Perron, Eitzman, Gillespie, & Pollio, 2008; Wenzel, Koegel, & Gelberg, 2000). People who live with mental illness and who experience homelessness face the challenges and consequences of both. A person who is homeless lives in extreme poverty and is exposed to adverse weather, sleep deprivation, hunger, and victimization (Patterson, 2007). These conditions and experiences directly contribute to poor mental health and physical illness (Hwang, 2001; Shaw, 2004; Shaw et al., 2006; Stafford & McCarthy, 2006). In this population, poverty and mental illness are obstacles to attaining and maintaining both housing and health.

Summary of Housing and Homelessness in BC

The intersecting social and individual factors that can lead to homelessness are well documented. The lack of affordable housing and poverty are major factors contributing to persons becoming homeless. Although providing clients with housing means that they are no longer homeless, they may be unstably housed for several reasons. Being housed does not resolve all the mental health and substance use issues that intersect with poverty and homelessness. Neither does being housed resolve the issues of poverty or the social stigma surrounding mental illness or substance use. I next explore how the ACT teams working within this complicated social context support clients in maintaining housing.

Chapter Three: Methodology

I use grounded theory as the methodology in this study. In this chapter, I describe grounded theory and its philosophical underpinnings. I then explain why this methodology is suitable and how I apply it to this study. I provide an overview of the study design and explain the participant recruitment process and related ethical considerations. I then outline the data collection and analytical techniques, describing how I ensured rigour in these processes.

What is Grounded Theory?

In the early 1960s, Glaser and Strauss developed grounded theory as a method of data collection and analysis. Glaser (1992) explained grounded theory as a methodology in which analysis is both linked to and concurrent with data collection. It “uses a systematically applied set of methods to generate an inductive theory about a substantive area” (Glaser, 1992, p. 16). In grounded theory, the research problem is identified from the participants’ perspectives, and the emergent theory is inductively grounded in the realities of these experiences (Glaser, 1992; Strauss & Corbin, 1990). Thus, grounded theory is firmly based on what is meaningful and important to the participants. Although the grounded theorist brings her own perspectives and interpretations to bear on the process, these interpretations are confirmed continuously within the data provided by participants. Hence, the goal of a grounded theorist is to develop theory from data (Glaser & Strauss, 1967) as opposed to testing an existing theory using data (Strauss & Corbin, 1990; Corbin & Strauss, 2008).

To ensure that a theory is truly generated from the data, researchers must be perceptive with regard to how their own knowledge and experiences can both inform the developing theory and impose bias on it. This awareness is called *theoretical sensitivity*. I developed theoretical sensitivity through reviewing the literature, my professional experiences as a street nurse, and my short time in working with an ACT team. This enabled me researcher to discern what is pertinent in the data, and it allows the development of a well-integrated theory (Strauss & Corbin, 1990, p. 41).

Grounded theory originally evolved through the theoretical perspective of *symbolic interactionism* (Morse, 2001, p. 2). George Herbert Mead laid the foundation for the theoretical perspective of symbolic interactionism as an approach to the research of social behaviour (Blumer, 1969, p. 1). Blumer, who was a student of Mead, coined the term symbolic interactionism to designate a sociological perspective that places meaning, interaction, and human agency at the center of understanding social life (Williams, 2008). Blumer identified three basic premises underlying symbolic interactionism (1969, pp. 3-4):

1. Humans act towards things based on the meanings they assign to them.
2. Meanings are socially derived, i.e., they arise out of the social interaction one has with others.
3. Meanings are handled in and modified through an interpretative process used by persons dealing with the things they encounter.

Rationale for the Use of Grounded Theory

Glaser (1978) stated that the researcher's goal is to understand the behaviour and meaning people give to their experiences in a natural setting (Glaser, 1978). Corbin and Strauss (2008) and Morse (2001) explained grounded theory as a method used to gather and analyze data, a process which could uncover how participants create, understand, and manage their experiences. Researchers use grounded theory when they investigate social situations or problems to which people must adapt (Corbin & Strauss, 2008; Schreiber, 2001) as well as to "discover and conceptualise the essence of complex interactional processes" (MacDonald, 2001, pp. 121-122).

Grounded theory is based on the assumption that participants in the study share a basic social problem that they need to manage or solve.

ACT teams share such problems when they work with their clients to attain and maintain housing. While ACT teams work to house clients and keep clients housed, many contextual factors either enhance or jeopardise a client's housing stability, thus influencing the team members' day-to-day practice in supporting their clients to attain and maintain housing. Because these two aspects make it necessary to adapt to situations and to understand complex interactional processes, the methodology of grounded theory is appropriate to the present study. The basic social problem with which ACT teams struggle is how to reconcile the variance between the clients' capabilities and characteristics and the conditions and expectations the client has to meet to remain housed. The teams resolve this problem by engaging in the social process of *supporting the client* to maintain housing, which involves providing the client with particular types of support that vary according to the situation.

In its provision of support, the team adjusts or adapts to these external factors and the circumstances that arise from them within a specific context. The team members interact with each other, their clients, and other agencies to support the client to maintain housing. The study of these interactive processes and adaptations is compatible with Blumer's second and third underlying assumptions: Meanings are socially derived (i.e., arise from the social interaction one has with others) and are handled in and modified through an interpretative process used by persons in dealing with the situations they encounter. Schreiber (2001) explained that in grounded theory, the researcher's job "is to investigate the socially constructed meaning from the participants' reality and behaviours that flow from that meaning" (p. 180). The goal of the researcher is to "develop a shared understanding of the relationship between the person, society and the phenomenon" (Schreiber, 2001, p. 178).

Society, in this study, denotes the societal structures (e.g., the team, the health authority, housing agencies, and the justice system) with whom the team members interact. In conducting this grounded theory research study, I sought to move beyond describing what the ACT teams do to support their clients to maintain housing to explain and understand the process by which this happens (Corbin & Strauss, 2008; Strauss & Corbin, 1998). I use grounded theory as a method to gather and analyze data that can reveal how the participants create, understand, and manage their experiences (Corbin & Strauss 2008; Morse 2001).

Grounded Theory Research Design

While conducting this research, I sought to understand the experiences of ACT teams in supporting clients to maintain housing from their perspective. I followed the methodology, seeking the participants' perspective, meaning, and understanding of their role in helping their clients to maintain housing. The goal of my research was to produce a substantive theory that reflects and explains the participants' experiences of providing support to these clients to reconcile the variance between the clients' capabilities and characteristics and the conditions they have to meet to remain housed. The participants work to reconcile the variance by providing the clients with the support required to the meet the conditions and expectations of being housed. Expectations are set by societal norms, by the various agencies and by the ACT team.

Overview

I started with the broad research question "How do ACT teams support clients to attain and maintain housing?" As I progressed, the sheer scope of the participants' work to help clients both attain and maintain housing led me to narrow the focus of the study (Strauss & Corbin, 1990). In consultation with my supervisor, I decided to focus on only the processes by which ACT teams helped clients maintain their housing. This decision was made for a number of reasons. First, there were at least three separate referral housing lists of clients waiting to be placed in housing. Indeed, this process of housing clients is complex and worthy of a study in itself. The participants did not understand the process of how client housing was attained and placements were decided. Much more work would be required to uncover the process of attaining housing. Second, to answer this part of the original research question—how clients attain housing—I would have had to recruit another set of participants, that is, people who understood the housing placement process. This recruitment process would have taken time, and as a novice researcher, I would have had to manage too many variables within the data. Third, because the housing placement process became centralized, the three processes for placing clients in housing changed during the course of the study. Furthermore, I became aware that the topic of attaining the housing of clients (although related to maintaining housing) was a separate study. Therefore, I focused on the participants' process of assisting vulnerable clients to maintain housing.

Many variants of grounded theory have evolved since its introduction by Glaser and Strauss (Dey, 1999; MacDonald, 2001; MacDonald & Schreiber, 2001). I chose to follow Corbin and Strauss's (2008) and Strauss and Corbin's (1990, 1998) approaches to grounded theory because their textbook and other publications clearly detailed a format for collecting and coding data. As a newcomer to grounded theory, I was further informed by Stern and Schreiber's (2001) textbook, Glaser and Strauss's (1967) seminal work, and Glaser's (1992) later work. The language used in this chapter reflects Strauss and Corbin's approach to grounded theory. Regardless of the approach to grounded theory used by the researcher, the development of all grounded theories is based on core elements (Charmaz, 2002; Glaser & Strauss, 1967; Mills, Bonner, & Francis 2006). These include *purposive sampling,* which is used to select participants who have knowledge about the phenomena (Schreiber 2001), *theoretical sampling* combined with the *constant comparative method* of data collection and analysis (Glaser &Strauss 1967), and the *inductive process* of developing concepts directly from the data to develop categories. Finally, these categories are integrated into a theoretical framework (Charmaz, 2000) of the social process of supporting vulnerable clients to maintain housing (see Figure 1)1).

Research Process

Recruitment of participants and ethical considerations. Participants were recruited for this study following the approval of the University and Regional Health Authority Ethics Committees. When the initial ethics application was prepared (Summer 2010), there were three regional ACT teams. Between then and the time of the study (March 2011), another team was introduced into the region, and the regional administrator requested that this team be included in the present study. This team had been working to support clients in the community for many years, and it was now identified as an ACT team using BC ACT guidelines. Therefore, an amendment to the ethics application was made. Prior to recruiting the participants, I discussed the details with ACT team administrators and team leaders and provided a synopsis of the study (Appendix S, Study Synopsis). Their permission was necessary to allow team members to participate in the study during work hours, and this was granted. Prior to the interviews, the consent form was reviewed with each participant, and informed consent was obtained. Each type of interview (focus group, shadow shift, and one-on-one) required a specific consent form. Ethical concerns related to maintaining anonymity and/or confidentiality for each interview type were made explicit in the both the information sessions and the consent forms, which are discussed below. Participation in the research was voluntary, and the participants were made aware that they could withdraw from the study at any time without penalty. They were informed that the data collected up until the point of withdrawal would remain in the database because the concurrent data collection and analysis in the grounded theory process meant that each person’s data would have already become integrated into the emerging conceptual framework and therefore could not easily be removed.

A major challenge in writing this thesis was to maintain the confidentiality of the participants while communicating the collaborative and relational nature of the data collection. I ensured confidentiality by using names to indicate the individual sources of quotations, but I drew these names from a previously developed list of fictitious names and randomly attributed them to the cited dialogues. Therefore, the fictitious names were not directly assigned to specific participants. Although a participant may have been cited more than once, each citation could be attributed to a different name, which made it impossible for readers to identify individuals by putting together all the quotations attributed to a particular source. This procedure thus protected the identities of the participants while preserving the “feel” of participant engagement through the use of quotations attributed to individuals.

I did not identify the participants’ disciplinary backgrounds because this could have compromised confidentiality. To maintain the confidentiality of the teams, I did name the health authority or the housing agencies. Although used as data, reports generated about the teams and their work with other agencies were not referenced in order to maintain confidentiality. The term “regional ACT teams” has been used throughout this study.

Participant selection. Grounded theory methodology requires that each participant has some experience of the phenomenon being studied (Schreiber 2001). At the initial stage of my research, data were systematically collected from participants with experience in supporting clients to attain and maintain their housing. As explained above, this approach to selecting participants is known as purposive sampling.

The participants were mental health outreach workers, social workers, police officers and nurses. All participants were clinically engaged in outreach work, supporting clients in the community setting, and they had direct contact with clients, landlords, and housing staff. All participants had experience and training in mental health or addictions, or both. I also sought the perspectives and the experiences of people who led and co-ordinated the teams, such as team psychiatrists and team leaders. The team leaders were either registered nurses (RN) or social workers. With the permission of the law enforcement agency, law enforcement personnel were also recruited because they work closely with the teams. One team was assigned an officer who worked as part of the team. Two other teams had access to a designated police officer with whom they worked closely. The fourth team did not have an assigned officer.

By selecting participants from all disciplines and all four teams, I was able to obtain a wide variety of perspectives, experiences, and points of view, which is in keeping with the principle of purposive sampling as well as the requirements of the methodology. I also interviewed a person who had eight years of experience working as a staff member in various types of supportive housing within both non-profit and health authority organisations in the geographical area. This person was not an ACT team member, but offered to participate upon hearing about the study. It could have been beneficial to include the perspective of more housing staff members to gain deeper insight into the issues the ACT participants identified, and the context in which they occurred. However this study specifically focussed on the teams. Otherwise, the recruitment of participants was directly carried out as outlined in the ethics proposal (see Appendix, V Ethics Certificate)

To ensure that the participants did not feel coerced by or obligated to me, they were recruited via a neutral third party, an administrative assistant, who distributed the poster outlining the purpose of the study and my contact information through an e-mail to the staff of all four teams. The administrative assistant also placed the poster in the shared areas of the teams' workplaces (Appendix A, Recruitment Poster). This method of recruitment avoided coercion and safeguarded confidentiality. The administrative assistant also arranged meeting rooms for the focus groups and onsite interviews and assisted me in co-ordinating information sessions for the regional teams. In accordance with the ethics proposal and the directions from the ethics committee, the administrative assistant sent e-mail to all team leaders, psychiatrists and law enforcement staff (Appendix B). I was invited by two of the teams to meet with them and provide information about the research study. I also invited the team members to attend an information session at a central location where they had the opportunity to ask questions about the study for their clarification (Appendix C, Information Session for Team Members). At the end of the presentation, the participants either self-identified as wanting to participate in the study or contacted me by phone or e-mail in response to the session or recruitment poster. The participants indicated whether they were prepared to participate in both of the two focus groups, a shadow shift, or an individual interview. My intent was to have participants sign up for one type of interview, either the two focus groups, a shadow shift, or a one-on-one interview. However, participants who expressed an interest in participating in both the focus groups and a shadow shift were able to do so.

I had planned to attend team meetings. However, because this was not arranged, Appendix D, “Interview Discussion Topics Post Team Meeting,” was not distributed to the participants. The focus group consisted of six people. In total, there were 12 study participants, and I completed 17 hours of field observation. I conducted 12 one-on-one interviews (including follow-up interviews). I also reviewed publicly available reports about the ACT teams’ involvement in the court system and the content of these reports were coded and became part of the data. I also read official media releases about ACT teams and this provided information as to how the studied ACT teams fit as part of the regional initiative to break the cycle of homelessness. I consulted the provincial ACT guidelines and documents used by the teams for charting and housing referrals. Examples of documents (without client information) that were used by the participants for charting became part of the data in that they allowed me to see how the information was prioritised and organised and what was considered to be important. The housing referral criteria also became part of the data and were coded and the housing referral criteria substantiated the participant's description of the process for rehousing clients.

I consulted the housing agency websites because they provided information with respect to the type of housing, staffing, and the services provided onsite. This information was not coded but I corroborated the information with data obtained form the participants. Participants discussed their interactions with housing staff much more frequently than their interaction with landlords. I was concerned that I was obtaining an unbalanced view of the ACT teams experience of supporting clients to remain housed. I obtained statistics of the percentage of ACT clients housed in staffed housing and market rent sites this helped substantiate the extent of ACT team housing staff interactions (approximately only 28% of clients are housed in market rent).

I also reviewed a regional police report and statistics related to ACT clients, including their housing status, reasons for loss of housing, and the number of clients who were stably housed and therefore I obtained a snap shot of the housing situations of clients for the ACT teams. The documented reasons for housing loss aligned with the participant's experiences. This was not added to the data as I had know way of knowing if the document provided new data or instances of housing stability or loss discussed by the participants. There were two regional documents that addressed and discussed the work of the ACT team in supporting in housing. The information contained in these documents was coded and analysed especially where direct quotes from ACT team members were used. Documents discussing the ACT team member's interactions with the court system and the ACT teams perspective were also coded and became part of the data and analysed. I conducted to focus groups.

The focus group provided me with a broad idea of what the teams did in their work with the client to maintain housing (Appendix E, Focus Group Discussion Question). The focus group discussion allowed me to obtain a variety of perspectives and differing points of view. I was also introduced to the language used by the team, and I asked for definitions and clarification of terms. The second focus group was conducted toward the end of the data collection, which allowed me to discuss the emerging theory and to determine if it had saturated major categories (Strauss & Corbin 1990). I also conducted follow-up interviews with clients. Three of the six participants attended the second focus group discussion (one participant was no longer with the team, another had a scheduling issue, and the third had a client crisis). A sample of the type of questions that I expected to ask during each type of interview—the shadow shift, team leader interview, police officer interview, and team member interview—were submitted to the ethics committee. These are included in Appendices F, G, and H. Appendix J was not used because I did not interview a financial aid worker. However, participants in the roles of social worker and team leaders were able to provide much of this data. The consent form for each type of interview, the focus groups, the shadow shift, and the one-on-one interviews are provided in Appendices K, L, and M, respectively.

In both the information sessions and in the consent forms I drew attention to the fact that the anonymity of the teams could not be guaranteed. Although the geographical regions of the teams are not identified in this thesis, readers who are familiar with the history of ACT teams in BC and their work could perhaps identify the geographical locations and therefore determine which teams were involved in the study. However, I explained that neither participants' names nor their identifying information would be included in the published research or presentation of the data. Any information that could potentially identify the participants would be withheld. Consequently, individual team members would not be identifiable and their confidentiality will be maintained.

The participants were provided with a list of counseling services (Appendix T) that they could consult in the event that discussion and/or reflection caused distress or that the participants became aware of their level of stress, These services are generally covered by employee medical insurance. This study was classified by the Health Board University Ethics Council as being of minimal risk to the participants because they would not be exposed to any harm during the study that was greater than they would encounter in their day-to-day work. However, the work of the participants is inherently stressful and the practice setting is challenging.

The study participants. The preliminary data for this study was generated from a focus group that consisted of six participants and included mental health outreach workers, social workers, and nurses. The focus group discussion was audio recorded to facilitate accurate transcription, which would to assist in verifying the data during analysis. A professional transcriptionist, who signed a confidentiality agreement, (Appendix U, Transcriptionist's Agreement) transcribed all but two of the interviews conducted during this study; I transcribed the remaining two. To check for accuracy I read and re-read the transcripts while listening to the audio recording, which not only allowed me to confirm the accuracy of the transcripts but also helped me to become very familiar with the data and therefore could be considered a preliminary step in the analysis. The focus group discussion was semi-structured, and open-ended questions were used. Guidelines for the focus group were also discussed.

Data Collection

To allow me to conduct the focus group discussion without distractions, someone assisted me in the data collection process by taking written notes and audio recording the discussion. This information and the name of the assistant were written in the consent form for the focus group discussion. The person who assisted me also signed a confidentiality agreement.

I reminded the participants of my intent to audio record at the beginning of each of the two focus group sessions. During the second focus group discussion, I discussed my analysis to ensure its accurate representation of their experiences, and I requested clarification when needed. Participants were also told that they could decline to answer questions, and they were discouraged from engaging in any discussion or providing information that they did not feel comfortable sharing.

The focus group participants were reminded at the beginning of each session that the information discussed within the group was completely confidential and should not be discussed outside the group. They were also reminded that because each individual was part of the group, anonymity was not possible within the group. A clause specifying the need to maintain confidentiality within the group and my obligation as a researcher to maintain confidentiality in writing the thesis and presentation of the research data was included in the consent form. I acknowledged the busy schedules of the participants and provided snacks, tea, and coffee as refreshments.

I further attended three shadow shifts or “buddy shifts.” Participants from three of the four teams volunteered to allow me to accompany them during part of their shifts. The shifts lasted four, six, and eight hours. The shadow-shift participants were advised that because they would be seen with me during their shift, they would be viewed as participating in the study. Consequently, I could not protect their anonymity; however, I could and would protect their confidentiality.

During the shadow shift, I observed the participants’ day-to-day interactions with clients and housing staff, the types of accommodation provided for clients, and the locations and physical environment where the clients were housed. In this situation, I was an "observer as a participant" (Speziale & Carpenter, 2007, p. 42). Because I was present and introduced to the client, I was a participant. However, although I shadowed the participants during part of their working day, I did not participate (Speziale & Carpenter, 2007) in the provision of clinical services; nor did I interview the clients.

Shadow shift participants were provided with a "clinician's script" (Appendix R), which was an ethical consideration; it guided the participant to ask the clients in advance whether the researcher could accompany him or her on the next visit. The participant was to emphasize that the client was under no obligation to agree that the researcher be present and that the participant would still visit the client if the researcher were not present. No information would be collected about the clients that we visited, and if the clients wanted to speak with the participant privately or the clients looked or felt uncomfortable, the participant would ask the researcher to leave (Appendix R, Clinician's Script). To minimise inconvenience, the participants were free to choose the day and the time that I would accompany them. During the "shadow shift," I made it clear that if the participant decided I should not accompany them on a specific visit, I would respect that decision.

When it was feasible, between visits to clients, I audio-recorded my conversations with the participants. No audio recordings or notes were taken during client–participant, landlord–participant, or housing staff–participant interactions, and no audio recording or note taking was done in public. Field notes were audio recorded and/or written notes were made in the field when I was alone, using the method (i.e., audio recording or note taking) that was convenient and practical at the time.

The audio-recorded and written field notes contained my descriptions of an event or interaction that I observed during the shadow shift, my thoughts and ideas about what I thought was happening, and analytical remarks and questions that arose from my observations. I also made written notes or audio recorded information about the housing that we visited in terms of the location, proximity to services, upkeep of the building, whether the building was staffed and how, and the level of surveillance and security. In the field, I was also able to observe formal and informal communication between team members, including how their safety was ensured and managed, how workloads were shared, and how their days were organized. The field notes from the audio recordings and the written notes were entered into the database as soon as possible after each shadow shift (Strauss & Corbin, 2007), and were included as a source of data. Most of the field notes were generated from the shadow shifts; however, I often wrote brief notes at the end of the interviews and the two focus groups. There are 22 pages of field note data in the database. Participants were informed that all data and documents related to the study would be retained in a locked filing cabinet in my home office. I am the only one with a key to the filing cabinet.

Constant Comparison Analysis

In a grounded theory study, "data analysis starts as soon as there is data at hand" (Schreiber, 2001, p. 55). The data collection and analysis process occur concurrently throughout the study. In the cyclical process (Lingard, Albert, & Levinson, 2008) of constant comparison, existing data are compared for similarities and differences by comparing incidents with incidents in the data, incidents with concepts, and concepts with concepts (Glaser, 1998). In this process, newly collected data are compared with previously collected data; incidents that are recorded in the data are compared with each other; and new and emerging concepts are compared with previous concepts. Questions arising from comparing the data inform the next cycle of data to be collected. Constant comparison leads to the identification of patterns, emerging themes, and concepts within the data. It also allows for the comparison of data with an emerging theory. This is known as *theoretical* *sampling.* That is, ideas and concepts emerging in the analysis guide the collection of additional data. During this process, I wrote memos continuously.

Memos. Writing memos helped me to formulate and develop theoretical ideas. During the process of writing, I was forced think about the data, and I committed this thought process to paper. Corbin and Strauss (2008) explained "Memos are a running log of analytical thinking" and are "the products of our analysis." Memos are the "repositories" of our thoughts: our "working documents" (pp. 105-107). The memos contained both raw data and notes on the concepts generated from the data during each level of coding. They also contained analytical notes (theoretical memos) of the thought process, which took the raw data through to a theoretical concept. In keeping with the methodological process of theoretical sampling, the memo also contained a plan for the future direction of the research process. For example, when I identified unexplained differences, gaps, or underdeveloped categories in the data, I made a note to collect more data about the concept. In this case, the memo noted the questions to be asked, and the form in which the data needed to be collected, such as through observation or a review of the literature or documents. As the research study progressed, the degree of conceptualisation of the written memos increased. I began to understand the story behind the data (Corbin & Strauss, 2008).

Theoretical sensitivity

Theoretical sensitivity, "a personal quality of the researcher" (Strauss and Corbin, 1990, p. p. 40) refers to my awareness of the "subtleties and meaning of data" and provides me with the "capacity to identify relevant data," thus "enhancing [my] ability to generate theory" (p. 41). Furthermore, Corbin and Strauss (1990) explained that theoretical sensitivity allows the researcher to develop a theory that is grounded, conceptually dense, and integrated, and that the researcher can do this more effectively than if this sensitivity were lacking (p. 41). My awareness was the result of the knowledge that I bring to the research based on previous reading and my professional experience in the clinical area. Theoretical sensitivity allowed me to develop insights from the data during the research process and to develop theories explaining the relationships between concepts and categories. In fact, during the process, I found that I became increasingly sensitive to differences and variations within the data. During the data analysis, I reviewed the literature on emerging concepts and categories, which further increased my theoretical sensitivity.

This sensitivity, although it was enhanced by my professional experience, could also cloud my perception and be an impediment to theory generation (Morse, 2001, p. 12). For example, early in the study, in discussing my data and analysis with my supervisor, in passing I mentioned "engaging the client." My supervisor asked what the process of engaging the client involved and what it meant. I had not looked closely at this important client–participant interaction, which begins during admission, and I was startled that I had neglected this crucial aspect. On reflection, I realised that I had believed the need for engagement was obvious. Indeed, engagement was a word that I had routinely used in the context of my work as street outreach nurse, and it was part of my practice. I thought that the concept and meaning were clear and explicit. I returned to my data to examine this concept and confirm what the participants had said. My professional experience and understanding led to my curiosity about the concept and sensitised me to ask further questions about the existing data. However, in analysing the data, I had to be careful not to assume that my experience would be the same as that of the participants (as I did initially), and I needed to ensure that that my theory about what was involved or happening represented the participants' perspectives. To accomplish this analysis effectively, I had to be aware of my own perceptions and biases and write memos to make them explicit. I focused on the data and looked for differences and variations within the data. Finally, I learned to question my interpretation of the data by examining how much my frame of reference could influence my interpretation and checking with participants to confirm that my interpretation was correct. In fact, my experience and that of the participants varied greatly. Although I had worked with a similar population, the context and conditions differed.

In the analysis, an important factor in ensuring both the clarity and lack of bias was the discussion of my data and its analysis with my supervisor. I also discussed the data, the analysis, and the emerging theory with my peers and an experienced grounded theorist, whose critique helped me to evaluate my findings and encouraged me to be accountable to the origin of my ideas and theories and to make explicit how they evolved from the data. This form of peer debriefing is a critical aspect of ensuring rigour in many types of qualitative research. Writing memos and diagramming my process of theory generation not only helped me to clarify my thought processes but also provided an account of my interactions with the data and the development of the emerging theory.

Coding Data

Initially, I coded data line-by-line and word for word, copying and pasting these lines and words onto index cards and using a spreadsheet to correlate the cards with the original transcripts. This became an unwieldy process. I attended a workshop on the use of NVivo and purchased the software. I then entered the existing data using the NVivo software and continued to use the NVivo computer software in the organisation and analysis of my data, specifically during open coding and the early stages of axial coding (discussed below). This software is designed for this use in qualitative research. However, I was not adept at using the diagramming feature of the NVivo product. Therefore, during the later stages of open coding and axial coding, when I began to formulate a theory about the relationships between the categories and to test those theories, I drew diagrams, wrote memos, and kept track of categories and their properties in notebooks. I found this method fluid and less inhibitory. I developed tables showing the major categories, their subcategories, and their properties (Tables 1-5). I use three levels of coding: open, axial, and selective.

Open coding. The data collected during the first focus group discussion and the three "buddy shifts" were transcribed and analyzed word-for-word and line-by-line. Key words and phrases were identified, analyzed, and labelled (Allen, 2003; Schreiber, 2001; Strauss & Corbin, 1990; Corbin & Strauss, 2008). Initially, I used the words and phrases of the participants verbatim to label the units of text, which is known as *in vivo* coding (Schreiber, 2001). Some examples of *in vivo* codes are "showing we are on their side," "doing what you said you would do," and "being there for the client." Concepts were abstracted from the data by using codes to label incidents, events, or actions that occurred in the data (Corbin & Strauss, 2008). The development and labelling of concepts in this way is the first step in theory generation. At this stage of the analysis, I had 480 open codes. I continued to collect and analyze the data using the constant comparative method discussed above (i.e., comparing data with data, incident with incidents, concepts to concepts) and identifying similarities and differences within the data (Glaser, 1992).

As patterns began to emerge, I organized the codes that shared similarities into clusters. Writing memos helped me to synthesize the codes and clarify the relationships between the basic concepts to determine how individual codes were similar or dissimilar and to determine and justify to which cluster the code belonged. During this process, the coding became more abstract. For example, the verbatim codes ("being there for the client,") "doing what you said you would do," etc.) were conceptually labelled with the higher order concept of *establishing credibility.* In conducting subsequent interviews and reviewing existing and incoming data, I questioned how "establishing credibility" was manifested in the participants' work, under what circumstances, and when. The need to clarify and develop concepts guided the sampling process and directed me with regard to the type of data I collected and the questions that I asked (Strauss & Corbin, 1990, p. 77), which is known as theoretical sampling, as previously discussed. For example, I later identified *establishing credibility* as a subcategory and subsumed it along with two other subcategories, under a major category.

Strauss and Corbin (1990) explained that researchers often found it difficult to strike a balance between their own knowledge and the reality of the situation that exists within the data. Given my work as a nurse, and my background in working with a population of people who experience marginalization, I expected the participants to talk about developing a trusting relationship with clients. However in reviewing the data, I realised that although some participants talked about trust, many referred to "the relationship" with the client as "the therapeutic relationship." When I re-read the transcripts I realised that follow up with the participants suggested that the relationship meant by the participants was therapeutic, in which trust, although a desired outcome, could be tenuous in some circumstances and had to earned. However, the participants believed that trust was important to the relationship. Throughout this study, I made sure that the concepts were empirically grounded. Being theoretically sensitive helped me to strike a balance (Corbin & Strauss, 1990) between my own knowledge and the reality within the data. As the codes generated during the first level of coding were collapsed into categories, I then became fully engaged in axial coding.

Axial coding. I continued to develop the categories and their properties based on theoretical sampling (Corbin & Strauss, 1990). At this stage in the coding process, theoretical sampling is used to collect data specifically to saturate a category and/or to develop and test a theory of the relationships between categories (Schreiber, 2001). In other words, each category must be fully developed (i.e., "densified") to understand what occurs within the category (Corbin & Strauss, 1990). At this level of coding, I sought to flesh out and develop the major categories of the grounded theory. For example, to develop the category, *Developing a Therapeutic Relationship*, I looked at the data to determine the conditions that gave rise to the development of the relationship, the context in which the relationship was established, and the actions and interactions that occurred during the process of establishing the therapeutic relationship. The data were compared for similarities and differences, and gaps in the data were identified. When a variation in the data was not understood or the conditions that led to an incident needed to be clarified, I collected data specifically to address these points.

Therefore, the grounded theory process is one of induction, deduction, and verification (Strauss & Corbin, 1990). I engaged in inductive enquiry by identifying trends and patterns in the data that informed the emerging theory and the formulation of the conceptual categories (Bryant & Charmaz, p. 608). Throughout the study, I also engaged in deductive inquiry and verification by checking the theory against the data (Strauss & Corbin 1990). Through the analytical process described above, I developed five major categories (Developing a Therapeutic Relationship, Reinforcing Capacity, Enforcing Conditions, and Negotiating Re-entry to Housing), which are discussed in depth in Chapter 4. I continued to write memos and use diagrams to develop, map, and test the emerging theories about the relationships between and among the categories. At this stage, I began to formulate a theory that explained the relationships among the categories and subcategories (Strauss & Corbin, 1990is). In the third phase, selective coding, I began to look for a core category that might link all the other categories (Schreiber, 2001).

Selective coding. Selective coding is an integrative process of selecting the core category by systematically relating the core category to other categories, validating those relationships by searching for confirming and disconfirming examples, and filling in categories that need further refinement and development (Strauss & Corbin, 1998). Strauss and Corbin (1990) guided the researcher to develop a story, which is a descriptive narrative about the core category or central phenomenon that relates to the categories. Reinforcing Capacity emerged as the central theme and the core activity in the story of how the ACT teams supported the clients to remain housed. I now provide a synopsis of the grounded theory**.**

Synopsis of the Grounded Theory

The grounded theory in relation to this study unfolded as follows. To resolve the basic social problem of reconciling the variance between the clients' characteristics and capabilities and the conditions the client has to meet to remain housed, the team focuses on *supporting the client* to maintain their housing (the basic social process). Reinforcing Capacity is the core category in that basic social process. To reinforce the client's capacity to remain housed, the ACT team engages in an iterative and continuous process of Learning How to best provide support while concurrently Developing a Therapeutic Relationship with the client. Without this relationship, meaningful client–team interaction cannot take place. Within the process of Learning How, the team acquires the knowledge and insights to inform the strategies used *in* Reinforcing Capacity and how to work with the client and other agencies when Enforcing Conditions for community living. In Enforcing Conditions, the team works with a third party (e.g., a police officer or judge) to ensure the client meets the conditions for community living and understands the consequences of not meeting these conditions. Enforcing Conditions is also a way to reinforce the client's capacity to remain housed. Despite the team's best efforts, some clients lose their housing and the team subsequently negotiates the client's re-entry to housing (Negotiating Re-entry*).* A theoretical model of this basic social process is shown in

Figure 1 of Chapter 4 and is discussed in depth in that chapter. The core category, Reinforcing Capacity, therefore, is at the heart of the theoretical model.

Rigour

In judging the rigour of a grounded theory, the trustworthiness and credibility of the research are examined (Morse, 2002). Strauss and Corbin (1990) used the criteria of fit, understanding, generality, and control to judge rigour. These criteria suggest that if the theory is carefully induced from diverse data, then it will fit that substantive area, and there will be clear connections between the raw data and the theoretical categories. The theory will represent the realities of the people working in the area, make sense to them, and it will be easily understood. In order for the theory to be transferable to other situations, it cannot be too abstract or narrow, and it must be generally applicable to the practice area under study and to similar practice areas. When the theory is used in practice, it will provide a general guide to actions that produce and predict change and control consequences.

In order to build rigour in developing my grounded theory, I worked to stay true to the process of grounded theory in the data collection and analysis by using the constant comparative method of making theoretical comparisons of the data, and identifying theoretical questions derived from the data, In addition, during the analytical process, I was aware of and identified prior theoretical sensitisation, memo writing, and diagraming (Strauss & Corbin, 1990). By reviewing memos, interview transcripts, and theoretical diagrams, I was able to observe the emergence of theory from the data. In addition, I discussed the emerging theories with the participants, thus substantiating the former (Chiovotti, 2001) in a process known as member checking. During the initial interviews, a theory began to emerge regarding two areas of the participants' practice, harm reduction and the identification of the need to focus on clients' strengths. However, there seemed to be a disconnection between the practices as identified by the participants and their actual practice in the context of supporting clients to maintain housing. Subsequent interviews gave me the opportunity to affirm or modify my suppositions and to clarify the participants' meanings (Chiovotti, 2001). I also reviewed the grounded theory diagram one of Chapter 4, with two participants and discussed the findings with the second focus group.

The discussions with the participants also helped me to develop theoretical sensitivity and provided me with a direction for theoretical sampling. These activities—the use of memos, self-reflection, member checking, and the presentation of emergent theories to grounded theorists (peer debriefing)—helped me stay true to the data and ensure rigour.

Summary of Chapter Three

In this chapter, I described the data collection and analytical techniques used in this study as well as how rigour was ensured in the process. I provided an overview of the study design as well as the participant recruitment process and related ethical considerations. In the next chapter, I discuss the findings of the data analysis. As a reminder to the reader, the research questions addressed in the findings are as follows:

1. How do the participating BC ACT teams support their clients to maintain housing within the current social context?
2. What specific challenges do the ACT teams encounter and struggle with in supporting their clients to maintain housing? How do they respond these challenges, and what strategies do they use to address them?
3. How do the ACT teams balance the competing demands of the provision of therapeutic services with housing stabilisation?
4. What are the factors that promote or facilitate housing stability and incur instability?

Chapter Four: Findings

In this chapter, I discuss the main social problem challenging the ACT team member participants, and I detail the social process they use to resolve this problem. I describe five major categories that are integral to this process. The participating ACT teams work to support a heterogeneous population of people who suffer from severe mental illness and/or addiction. Many of these people have experienced homelessness, and they remain vulnerable to housing loss.

The ACT teams work with their clients to meet the conditions and expectations inherent in being a tenant and a neighbour. The conditions and expectations are set according to societal norms, the Residential Tenancy Act, and the rules and policies of the housing agencies. However, many ACT clients are compromised in their capabilities to meet these conditions and expectations. Consequently, there is a variance between the conditions the clients have to meet to remain housed and their capabilities and characteristics. The extent of this variance is different for each client, which constitutes the main social problem that the participating ACT teams struggle to resolve—the resolution of this variance. Central in supporting clients to stay housed are the teams' strategies to reinforce the client's capacity for housing stability. Therefore, Reinforcing Capacity is the core category in the grounded theory of supporting vulnerable clients to remain housed. Hence, all other categories relate to the core category of Reinforcing Capacity.

In this thesis, different fonts are used to distinguish the various levels of concepts within the grounded theory. Each major or first-level category is capitalized (e.g., Reinforcing Capacity) throughout this document. The subcategories of the major categories are italicized (e.g., *containing chaos*). Finally, third-level strategies appear in Arial narrow italics (e.g. *providing structure*). These third-level subcategories include a range of concepts that relate to the second-level subcategories, which include *strategies, types, circumstances, conditions, and consequences.*

Figure 1 shows the complex social process used by the ACT team to support their vulnerable clients to maintain housing. The following supplementary material shows how the components of the grounded theory fit together: 1) the diagram of the social process of this grounded theory (see Figure 1); 2) the table provided at the beginning of each new major category, which identifies the subcategories associated with each major category, as well as the types, circumstances, conditions, or strategies that explain each subcategory (see Tables 1–5). I now provide an overview of the grounded theory of supporting vulnerable clients to maintain housing. I briefly define and describe each major category and their subcategories within this theory. I then detail the findings within each category.

The Grounded Theory:

Supporting Vulnerable Clients to Maintain Housing

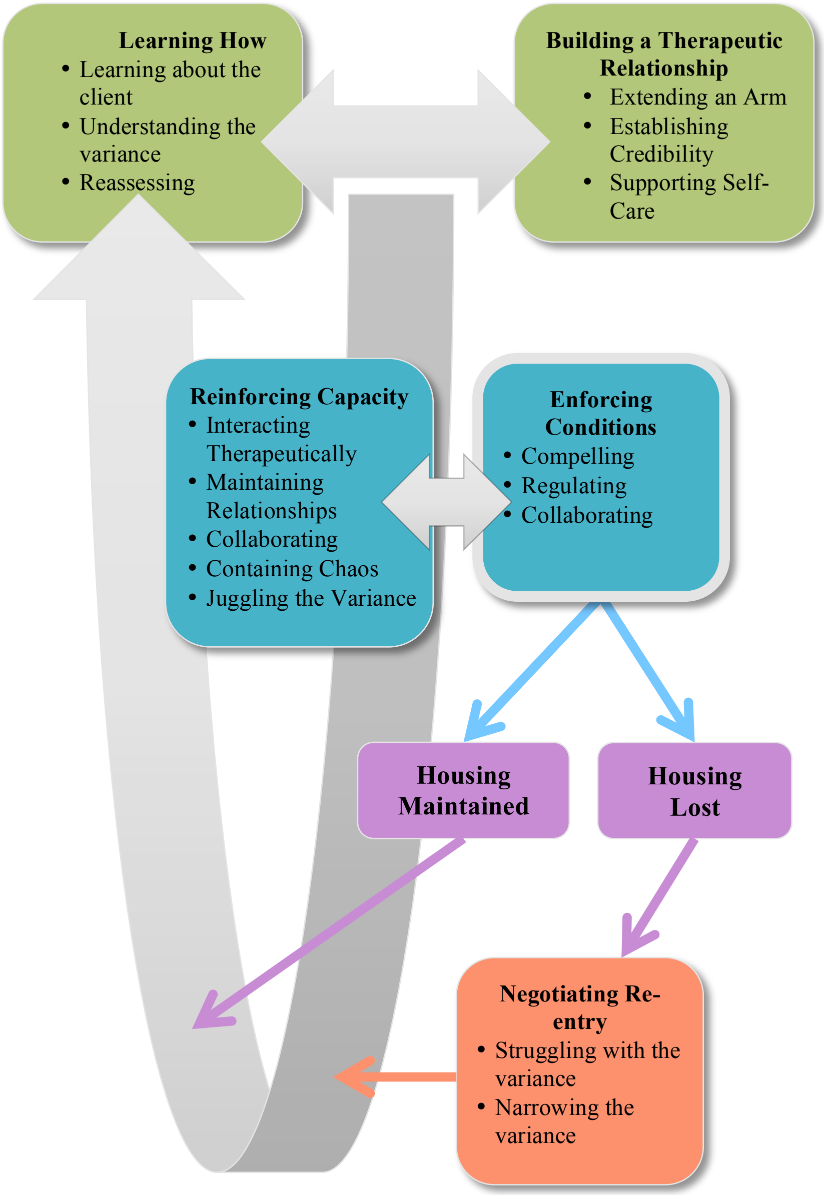
Learning How
Learning about the client
Understanding the variance
Reassessing
Building a Therapeutic Relationship
Extending an Arm
Establishing Credibility
Supporting Self-Care
Reinforcing Capacity
Interacting Therapeutically
Maintaining Relationships
Collaborating
Containing Chaos
Juggling the Variance
Enforcing Conditions
Compelling
Regulating
Collaborating
Housing Maintained
Housing Lost
Negotiating Re-entry
Struggling with the variance
Narrowing the variance

Figure 1. Schematic of the Basic Social Process. The white arrow between the green boxes indicates that they occur concurrently. The large sweeping arrow indicates a continuous ongoing process. Reinforcing and Enforcing are in the spectrum of the provision of support.

Overview of the Basic Social Process of the Grounded Theory

In order to support vulnerable clients to maintain housing, the participants engaged in five major processes: Learning How, Developing a Therapeutic Relationship, Reinforcing Capacity, Enforcing, and Negotiating Re-entry. These five processes are not necessarily sequential, but they are interdependent and iterative. These five processes are the major categories of the grounded theory of how ACT teams support vulnerable clients to maintain housing. Below, I first provide an overview of the entire grounded theory and then describe each major category and its subcategories in detail.

In Learning How, the ATC team participants become familiar with clients and learn how to support them to remain in housing. This major category involves learning about the client, understanding the variance, and reassessing clients and their housing situation. Learning about clients is initiated upon admission by assessing them and obtaining their history. Understanding the variance moves beyond assessment to learning and understanding how clients' histories and life experiences have influenced their capabilities to meet the conditions and expectations of being housed. In understanding the variance, the team member gains a perspective on clients' strengths, capabilities, and struggles within their housing situation. The process of understanding involves knowing the clients' pathways to homelessness and learning about their history and life experiences. Reassessing clients and their housing situation takes place as strategies are re-evaluated and the team reviews its perspective, based on their evolving knowledge and understanding of their clients. Learning How is an experiential, iterative process that occurs over time and involves both the team and the client. Consequently, Learning How informs the strategies used in other categories, such as Developing a Therapeutic Relationship, Reinforcing Capacity, Negotiating Re-entry, and Enforcing Conditions. Therefore, developing a Therapeutic Relationship between the team and the client is essential in *supporting the client* to remain housed.

The central process of Developing a Therapeutic Relationship consists of the actions taken by the participants to foster the clients' confidence that the team members are both reliable and act in their best interests. Without the development of a therapeutic relationship, meaningful participant–client interaction cannot take place. This relationship is crucial for the team to provide adequate client support. In Developing a Therapeutic Relationship, the teams develop a working relationship with the clients to support their recovery and well-being, and they work through issues as they arise within clients' housing situation. Developing a Therapeutic Relationship includes the following subcategories: *extending an arm*, *establishing credibility.* In *extending an arm*, clients are supported in times of crisis, which is often the case when they are admitted to the team. The teams also have to *establish credibility* with their clients by demonstrating that they are working in their best interests. The team uses various therapeutic initiatives to support the client in housing, which are discussed under the next category.

Reinforcing Capacity encompasses the therapeutic initiatives and collaborative strategies used by the team members as they work with their clients to meet the conditions and expectations of being housed, according to housing rules and societal norms. To Reinforce Capacity, the participants engage in the following strategies: *interacting therapeutically, maintaining relationships, collaborating, containing chaos, and juggling the variance*. In *interacting therapeutically*, the participants use a range of strategies, such as counseling and *providing structure,* to support the client to remain housed. Paramount to the process of Reinforcing Capacity is *maintaining relationships*, not only with the client but also with the housing staff or landlord. *Collaborating* encompasses the formal and informal communication and strategizing that takes place within and among the ACT teams, the housing staff or landlords, and/or their clients to meet the goal of Reinforcing Capacity. The sub-category *containing chaos* concerns minimising the potential disruption that may result from the behaviour of a client. In the process of Reinforcing Capacity, the participants juggle the competing priorities inherent in a tripartite relationship among the ACT team, the client, the housing staff, and the landlord. I have called this sub-category *juggling the variance*, which designates the participants' struggles with the variance to determine the impediments in their work of Reinforcing Capacity. It also pertains to the larger societal, philosophical and policy issues that arise within the team's practice as they work within a system of services that purport to subscribe to Housing First and harm-reduction philosophies. I will discuss the latter later in the chapter when I discuss the findings within the core category.

Enforcing Conditions concerns *compelling* clients and *regulating* their behaviour to ensure that they live within the structure set by the rules and conditions of the Residential Tenancy Act, the Mental Health Act, societal norms, and the law. In the process of enforcing conditions, the ACT teams are also *collaborating* with the police and the judge in the integrated court system. There are direct consequences for these clients if they fail to comply with mental health treatment, break the conditions of tenancy, or do not meet the conditions set by the integrated court system (ICS). *Compelling* places obligations and pressure on the client to comply with these conditions. *Regulating* enforces the external conditions placed on the client. *Compelling* and *regulating* are intended to promote compliance with Enforcing Conditions.

Under these conditions, the team members need to collaborate with a third party, such as a police officer, probation officer, or judge; therefore, *collaborating* is also a subcategory of Enforcing. The participants identified that the structure imposed by the court system and the Mental Health Act can support their clients in maintaining their housing. However, the participants also identified the potential for these interactions to affect negatively the trusting relationships they develop with their clients.

Although many clients remain housed because of the work of Reinforcing Capacity and Enforcing Conditions, some may lose their housing. When this occurs, team members must work to ensure these clients re-enter housing, that is, Negotiating Re-entry. The participants then encounter situations in which they *struggle with the variance* [*struggling with the variance*] between the factors that led to the client's loss of housing and those that further marginalize the client and prevent them from rehousing. In order to rehouse the client, the participants work on behalf of and with the client to narrow the variance. *Narrowing the variance* concerns how the participants address the marginalizing factors and manage the barriers to rehousing clients, such as ensuring that the rent is paid.

In summary, in supporting vulnerable clients to maintain housing, ACT team members must reinforce the capacity of clients to remain housed. They do this by Learning How to support clients by gaining knowledge and understanding of them. Learning How to reconcile the variance is integral to Reinforcing Capacity because it informs the strategies used by the participants. Learning How to reinforce capacity is also an ongoing iterative process. Learning How and Developing a Therapeutic Relationship occur concurrently. Without the therapeutic relationship, Reinforcing Capacity cannot occur. Developing a Therapeutic Relationship is also an ongoing, concurrent process throughout Reinforcing Capacity and Learning How. When clients lose their housing, the teams then Negotiate Re-entry. The teams must Develop a Therapeutic Relationship in order to Reinforce Capacity and to engage in the process of Learning How because without a therapeutic relationship, meaningful team client interaction cannot take place. In some cases, the team works with both the client and the ICS to enforce conditions of community living.

I now discuss each major category in detail: Learning How, Developing a Therapeutic Relationship, Reinforcing Capacity, Enforcing Conditions, and Negotiating Re-entry to housing, as well as their subcategories. Preceding the discussion of each major category is a table of the conditions, circumstances, and types of situations that inform these sub-categories. I start with the major category of Learning How.

Table 1: Learning How

Major Category	Subcategories	Types Circumstances/Conditions
Learning How	*Learning about the client*	*Assessing the client* Mental illness Substance use Income Capacity to follow rules Social and health history Motivation to engage with the team *Matching and fitting* Identifying special or specific housing needs Identifying the level of support required Identifying strategies of support (used by the team) Identifying the clients eligibility for housing *Predicting potential problems* Obtaining a housing history Identifying triggers Identifying vulnerabilities Identifying strengths Consequence: Focusing on vulnerabilities Losing site of strengths
	Understanding variance	*Identifying factors that widen the variance* Knowing the clients pathway to homelessness Being de-conditioned Lacking skill *Gaining perspective* Understanding the struggle Understanding transitioning Understanding perceptions of home Understanding perceptions of permanence Understanding perceptions of ownership
	Reassessing	*Reevaluating the team approach* Respecting client choice Struggling with paternalism maternalism Removing choice *Continuing to learn* Going back to the drawing board Figuring it out Establishing the clients baseline

Learning How

The participants stated that all clients supported by the team require intensive support to remain housed. Most clients supported by the ACT team are perceived as having special or specific housing needs. In Learning How, the team gains the knowledge and information required to determine the support that the client requires as well as the understanding of the client’s capabilities to meet the conditions and expectations of housing. Learning How is iterative, experiential, and continuous. It informs the strategies used by the team to both reconcile the variance and support the client to maintain housing. Learning How has three subcategories: *learning about the client*, *understanding the variance*, and *reassessing*.

Learning About the Client

Learning about the client is a foundational subcategory of Learning How, learning about the client begins with the client’s admission to the ACT program and occurs over time. Learning about the client, as described by the participants, includes *assessing the client,* including their disability from substance use and mental illness, income, capacity to follow rules and motivation to engage with the team. The participants learn about the clients with a view to *matching and fitting* them to both housing and support by identifying special or specific housing needs, the level of support required, and eligibility for housing and stipends (financial support to pay rent). The participants also reported assessing the level of support that clients require with activities of daily living and their income. These assessments, combined with knowledge of the client’s history, ideally inform the process of planning client support and *matching and fitting* the client with housing.

Assessing the client. One participant, Alex, provided a comprehensive description of assessing clients and taking their housing history. His response to the question, "Tell me something about the work you do to help clients remain housed" confirmed what some of the other participants said in their interviews:

> Well, we look at where they've been [housed], what has worked, what hasn't worked [in their housing situation], assessing their current ability to perform activities of daily living and how that's impacted by whatever their mental health issue may be, their addictions, current addictions issues, and where they've been in the past. And their social support system and level of income.

According to Alex's response, the ACT team obtains the client's housing history, thus becoming informed about what has worked and has not worked for the client in the past. The team also assesses the client's level of disability from mental illness and substance use. The level of support required by the client to carry out activities of daily living (e.g., personal hygiene, mobility, housework, managing money, shopping, use of transport, and taking medications) is assessed. The client's income determines where he or she can afford to live and whether he or she is entitled to any monies from other sources, such as housing subsidies. Lack of money may exclude the client from market rental housing.

Many clients supported by the ACT team are perceived to have special or specific housing needs. The participants discussed how certain characteristics of clients require special attention in the assessment of their right fit with housing. Participants assessed some clients as being as being "vulnerable" because they have difficulty setting boundaries and may be taken advantage of by others. The inability to set boundaries can result in clients having disruptive or unwanted guests in their housing. Clients who are considered vulnerable may be housed in a building with a secure entrance that is controlled by staff and where there is surveillance of all visitors. If clients are actively using substances, they may be placed in housing that tolerates substance use, such as low barrier housing. If the clients' substance use or mental illness is debilitating, they may require housing that provides on-site support to assist with the activities of daily living. Clients may be perceived as having a reduced capacity to follow rules for a number of reasons.

No matter where clients are housed, they must adhere to the rules of the agency and respect the terms and conditions of tenancy. One team member, Lee, provided a further description of the client assessment in this context:

> We assess the client's motivation to engage with the team and follow -- or capacity to follow rules, whether it's through market rent, like the Residential Tenancy Act, or even rules put into place through a supportive housing site. So a lot of assessment involved initially. And their motivation to engage with the team and follow -- or capacity to follow rules.

As part of the assessment, Lee included the client's capacity to follow rules. During my further discussions with the participants, I realized that in this context, the participants generally did not refer to the client's legal competence or mental ability to make decisions, but to his or her capability to "understand and meet the expectations" and "responsibilities of being housed," "knowledge and experience of being housed," and knowledge and experience of the "constraints that exist within housing." The reduced capacity to follow rules for any reason leaves the client vulnerable to housing loss.

All participants reported incidents in which a client's tenancy was jeopardized when he or she could not meet the expectations and responsibilities of being housed, and in some cases was perceived by the participants to have neither the knowledge nor the experience of being housed, which increased the vulnerability of such clients to housing loss. The participants take an individualized approach, placing the onus of change and conformity on the client, with the team's support. A strength of the participants is that they identified and discussed the clients' vulnerability to housing loss as rooted in difficult social circumstances and mental illness experienced by clients.

The participants explained that some clients were identified as having reduced capacity because of brain injury secondary to physical trauma or having reduced capacity because of fetal alcohol syndrome, substance use since childhood, or current poly-substance use. Therefore, in these cases, the capacity of these clients was reduced for neurophysiological reasons. The participants' explanations of why some clients have a poor capacity to meet the expectations and conditions of being housed attributed these vulnerabilities to housing loss to historical trauma and the conditions to which clients have been exposed during their lives, such as violence and alcohol.

The participants are involved in *assessing the client* on admission by identifying the client's specific housing needs, his or her capacity to follow rules, social history, income, and motivation to engage with the team. These factors are all part of the process of Learning How to support the client to maintain housing. The team uses the information gained in assessing the client to inform the process of *matching and fitting* the client with appropriate housing, support within housing, and support by the team.

Matching and fitting. The participant's assessment of the client's capacity to meet conditions and expectations for any reason determines whether he or she can live independently in market rental housing, such as an apartment run by a landlord, or whether they require additional support within the housing setting. Some participants referred to this as *matching and fitting* the client with housing and appropriate support. Learning How concerns identifying vulnerabilities to housing loss, such as lack of experience or capacity. This knowledge informs the strategies used in Reinforcing Capacity*,* such as the provision of education. As discussed, many clients supported by the ACT teams are assessed as having specific or special housing needs. The participants talked about *matching and fitting* clients with housing that is appropriate to their needs.

However, once a referral is made to the housing placement agency, the team no longer has control of the process. Most participants expressed that once the housing referral was submitted, the process was "out of their hands." Although many clients are housed according to their needs, for a variety of reasons, *matching and fitting* may not happen, and the ideal is not always achieved. In *learning about the client*, in order to *match and fit* clients with housing, the participants reported identifying the level of support that the clients require both within housing and from the team as well as the type of housing that the client can access. The client's housing placement is determined by diagnosis, income, housing availability, and his or her housing history. These criteria for placement can create tension in *fitting* the client with appropriate housing.

The participants identified that no matter where clients are placed, strategies are established to help them fit their housing situation and to promote their retention of housing. In this context, many participants talked about the need to educate clients, implying that the team's support strategies would reconcile the variance (between clients and the conditions they have to meet) that results from a housing mismatch. The information gained in *learning about the client* informs *matching and fitting* clients with their housing and is a part of the process of Learning How, which informs the development of strategies to support the client to remain housed and thus reconcile the variance.

Predicting potential problems. *Learning about the client* includes *predicting potential problems*. The participants identified that obtaining a housing history was useful because they were able to review what had worked and not worked in the client's housing situation and predict potential problems and outcomes and identify triggers.

Like the other participants, Jay valued the importance of learning about the client's history:

> Looking at [the client's] history, as far as I'm concerned, has always been one of the best indicators of what the future kind of behaviour to expect and what that might unfold. History's important because I know, with our clients, I like to know what their triggers are, the things that, you know, have happened to them in their past, to understand their psyche and to understand where their weaknesses and strengths are, as far as their histories, which in turn helps with housing.

According to Jay, the client's history provides an indicator of what may unfold in the housing situation, that is, it can predict potential behaviour related problems. Housing history is a strong predictor of issues that could arise for clients who are already housed or for those who are being re-housed. Participants described the type of “future behaviours” that could potentially result in the loss of housing. As discussed by the participants, the issues include hoarding, which may infringe fire regulations, having guests when there is a limited guest policy, having guests who are considered disruptive, engaging in behaviours that disturb other tenants, the inability to communicate concerns, and aggression toward staff or other tenants. Thus, knowing the client’s history informs the team with regard to housing placement and the initiatives taken to reinforce the client’s capacity to remain housed.

The identification of triggers is enhanced when the participant has knowledge (or gains knowledge as they get to know the client) of events or situations that could negatively affect the client and elicit a negative response. These responses could range from social withdrawal and depression to anger and aggression, decompensation in mental health, or increased substance use. These responses increase the client’s vulnerability to housing loss. In discussing their experiences, the participants identified the need to recognise the client’s strengths. However, identifying vulnerabilities was usually the main topic of their discussions.

Anna also valued knowing the client’s housing history. She stated that the team considers where the client has been housed and what has or has not worked to keep he or she housed. This allowed the team to build on what has worked for a particular client. Jay noted that by reading the client’s history, he could also learn about the client’s strengths. Other participants spoke about how ACT team members identify client strengths, including Leslie, who referred to these as "protective strengths." When asked what this meant, Leslie responded:

> What I was getting at was identifying the client's protective qualities; not always looking at [the client's] limitations or weaknesses or things to work on, but more being on this is what the person has as qualities and strengths, as a protective factor. We're going to now examine protective strengths that we can work with, that are going to help. These strengths that they hopefully can use and implement in their day-to-day life.

This participant brought a strength-based focus to her practice by considering the qualities of the client that supported him or her in day-to-day life. The participant identified these strengths as the client's resiliency in surviving previous housing loss and relapse and the client's coping skills and capacity for hope. Leslie gave the example of a client who owned three mugs. The client wanted to take care of these mugs and not break them because she hoped to invite family members one day for tea without the stigma of being homeless. This client had struggled to retain housing in the past and had remained housed for six months in a prior housing placement. The participant viewed the prior loss of housing as part of a journey on which the participant and client were now focused, building on the client's prior success of having remained housed for six months, the accomplishment of being presently housed, owning a few cherished possessions, and the client's goal of having tea with her family in her own home. Hence, learning about what was important for the client had shaped her care plan.

The participants also expressed the need to focus on strengths although they generally focused on vulnerabilities and had difficulty defining strengths in the housing context. I was able to determine what constituted client strengths by considering the antithesis of client vulnerabilities and noting in their discussions what the participants focused on when they worked with their clients in the context of housing. The participants focussed on the following client characteristics: the ability to form relationships and interact socially; engaging with the team; a social support system; an interest and involvement in recreational activities; the ability to set boundaries; self-determination; making goals or plans; insight into their own mental illness or substance use; and the ability to communicate and talk about concerns or problems. The participants identified situations where vulnerabilities in these areas jeopardised housing; therefore, strengths in these areas were specific to maintaining housing and fitting into both society and the housing situation.

The participants were clearly aware of and sensitive to client factors that could increase vulnerability (*identifying vulnerabilities*) to housing loss. These included poor coping skills (e.g., becoming overwhelmed, angry, and increasing substance use); lack of social skills (e.g., poor communication and problem solving skills); difficulty setting boundaries (manifested in vulnerability to being taken advantage of by others, either financially or sexually, or disruptive guests); and having a substance abuse disorder. In the context of housing, strengths were often described as the client's compliance with rules and treatment, motivation to engage with the team, and social support. The strengths identified by the participants were the skills necessary to manage the responsibility of being housed. Necessary for fitting into society, these strengths are defined by the provider. When I asked participants about the client's strengths that supported them to maintain housing, they usually did not identify talents, motivation, resources, interests, beliefs, and competencies (McClam & Woodside, 2012). This predominant focus of the ACT team on client vulnerabilities is because the participants need to pre-empt problems (as discussed in Learning How) and to ensure the client's compliance with housing conditions in order to remain housed.

One participant explained that when discussing a client's issues, other team members often identified and framed the client's strengths. They cited the example of a strength as the client's having guests because it indicated that he or she was now forming relationships and interacting socially. When the participants discussed how they supported clients to remain housed, it became clear that some issues might sometimes be so complex and pressing that the team made best-interest decisions and/or focused on the client's vulnerabilities and struggles. Strengths could also be formally identified and routinely used to balance vulnerabilities, which, however, did not currently take place formally. Examples include identifying and correlating vulnerabilities to housing loss, which was variously discussed, and the clients' abilities to offset these vulnerabilities with their unique strengths.

Learning about the client provides the team with a foundation for determining how best to support vulnerable clients to remain housed. *Assessing*, *matching and fitting,* and *predicting* form part of the framework in which Learning How to best support the client to maintain housing takes place. The second subcategory of Learning How*, understanding the variance,* moves beyond assessment and obtaining a history to understanding how the client's history and life experiences influence his or her capability to maintain housing.

Understanding the variance.

The second sub-category moves beyond assessment to learning and understanding how the client's history and life experiences influence his or her capabilities to meet the conditions and expectations of being housed. *Understanding the variance* relates to Learning How because it contextualizes the client's capabilities and the reasons that he or she may or may not have the capacity to meet the conditions and expectations, thus informing the strategies used to reconcile the variance. *Understanding the variance* includes *identifying factors that widen the variance* and *gaining perspective*.

Identifying factors widening the variance. Fran expressed her perspective on what might influence the interface between a client and his or her transition into housing, explaining that each individual's pathway to homelessness differs and that the reasons for homelessness are diverse. She described some people as being "second generation" homeless, meaning that the person's parents experienced periods of homelessness. She explained that some clients are homeless because of poverty, whereas others, usually those with severe mental illness, withdraw from society and isolate themselves from others. She also talked about individuals who become stuck in the cycle of homelessness because of poverty and substance use, thus becoming entrenched in the street:

> So there's different types of homelessness. There's, like, some categories. There's people who are really street-entrenched and it's -- perhaps their family, their parents are even homeless, so there's this other second generation and they haven't really known anything else. And then there's people who, you know, maybe because of their mental illness were, like, in the bush, alone, homeless. So there's different types of homelessness, if

> you will? Like -- and how that looks for people, depending on their -- if it's mental health or addictions. Like, addictions people tend to be more street-entrenched, you know. So -- or really chronically mentally ill people maybe just isolate out in the woods or something like this. Or use shelters or -- there's people who just use the shelter system because they can't really afford a place. So where are they -- where are they [the clients] coming from? And then that is going to reflect in how they transition into having a home.

The key point here is that there are different entries to and diverse reasons for homelessness. Knowing the client's pathway to homelessness and understanding the different entry points, the type of homelessness, and the experiences of homelessness help in understanding the variance and why a client may struggle to remain housed. This understanding potentially informs the strategies used in *supporting the client* to maintain housing. Coming to this understanding is part of the process of Learning How.

Fran clearly described the pathways to homelessness as extreme poverty, impoverishment, societal exclusion, and childhood homelessness. She also discussed the transition to street entrenchment and living the confirmed street lifestyle of sleeping rough. Fran believed that each client's experience and reason for being homeless was "reflected in how they [the clients] transition to having a home."

The ACT team, to be effective in its provision of intensive support, needs to take into account their clients' experience of homelessness. The team members are aware that this experience provides insight into how their clients might cope with the transition to housing, their potential struggles and strengths, and their capacity to live within the housing rules to maintain their housing. If clients are "de-conditioned," used to a rough, violent, and chaotic lifestyle, or has experienced the extreme poverty of chronic homelessness and living on the margins of society, as described by Fran, the variance between their capacity to meet societal norms and the expectations placed on them can be wide. As both Fran and Dana stated, the capacity of ACT clients to remain housed is situated in the larger social context of their history as it relates to childhood development, poverty, and the physical and social environment of living rough and homeless. This knowledge provides insight into why individuals may not have the necessary skills or why they might struggle to remain housed.

Dana contextualised the need of ACT clients for intensive support:

> I think some [clients] have the skills and abilities but they have become de-conditioned. It's like they're out of shape and we take them on and we try to help them get reconditioned. It's like anything, you know, like I haven't been running for the past few months, now I can't run at all. Some clients have never had the skills because they come from really traumatic backgrounds where they didn't have appropriate role modelling -- and love and parenting -- but some [clients] are just de-conditioned. They've just become -- adjusted to a street lifestyle, which is very chaotic and very violent and abrasive and blunt and all that…

Dana believed that some clients have the skills to maintain their housing but need support in meeting its demands and becoming "reconditioned" to meet the responsibilities of being a householder, a tenant, and a neighbour. Dana also observed that for a combination of reasons, some clients have not had the opportunity to develop the skills needed to maintain housing. A common factor shared by ACT clients who have a history of homelessness and living on the streets is that they have developed skills to live in an environment that is rough, violent, and chaotic. This type of environment can "de-condition" clients in terms of tenancy skills. Because they are de-conditioned or unskilled, clients may struggle with living in a structured environment, dealing with the practical issues of being a tenant, and relating to or interacting with other people, such as neighbours, landlords, and housing staff. Clients may have difficulty responding constructively to issues that arise within their housing situation. How clients cope with stress and how they respond to tense situations are often shaped by their life experiences. Leslie provided further insights into what the ACT team and some of their clients struggle with in this respect:

> When you're looking at [this city] or anywhere, housing is very much situated by the social expectations, the social norms that we all kind of grow up with; expectations around behaviours and what those expectations look like. And obviously they transfer into the housing: Be good. Don't be angry or mad or mean towards your landlord. Talk about what's bothering you. But I mean it obviously doesn't always function with the people that we're necessarily working with.

In other words, the participants' experience is that some ACT clients have difficulty meeting these social expectations and societal norms. This difficulty becomes apparent in the client's day-to-day interactions. The participants provided examples of clients with problems in communication and/or in social interactions. Some clients lack the ability to manage conflict or communicate their concerns. This can become apparent in the clients' interpersonal interactions and their responses to problems and conflicts that arise. These problems can manifest within the housing situation in altercations between the client and the housing agency staff or landlord, between the client and other tenants, and between the client and their guests, which sometimes jeopardizes the client's housing status. The client's ability to engage in community life, interact socially, and form relationships is a predictor of how he or she might engage and interact with people in their housing setting because it is situated within the context of his or her social and life history. Clients may not have the capacity to meet expectations because of historical trauma and the conditions in which they were exposed to violence and alcohol. *Understanding the variance* helps the team identify factors that influence the client's capacity to follow rules or that can increase his or her vulnerability to housing loss. The team members can best learn how to support their clients by *gaining perspective*.

Gaining perspective. The participants identified situations in which their own reference points (the baseline from which they interpreted the world) differed from those of the client, such as understanding the concepts of home, permanence, and ownership. One participant explained, "What you and I consider to be home may be completely different from what the client considers to be home." For example, home to the client may be a place to sleep and keep their harm-reduction supplies, whereas for others it may signify the hope of eventually having a family member over for tea without the shame of being homeless.

Another participant spoke of realizing that clients often lived in a world of instability, loss, and constantly relocation. Therefore, the notion of permanence, although part of our lives, is not a reality for some clients. Another team member explained that her client's perception of ownership differed from her perception of it. For some clients, the ownership of anything was "fleeting" and could be short-lived on the streets. For instance, a client might use a shopping cart to store their possessions: “The cart could be stolen from them at any time, and it did not belong them in the first place because it is owned by Save-On-Foods.”

Differing perceptions of permanence sometimes surface, and some participants work hard with clients to help them engage with their housing. A small number of clients had difficulty believing their housing was permanent, could not engage with their housing immediately, and chose to live elsewhere or sleep on the street for periods. The participants determined that it was important not to be judgmental, label the client as ungrateful for their housing, assume that the client chose to live on the street, or that the housing should be given to someone else who wanted it. A client might hoard or keep what would be considered garbage in their housing or continue to use a shopping cart. The client also might not have the same criteria for hygiene, such as showering or cleaning. The team identifies these issues and factors them into care planning, such as helping the client clean and working with them to clear one section of the room at a time or having an outside agency come to clean.

These participants gained an understanding of the client’s experiences and examined their own reference points in relation to these experiences. Developing perspective both through *understanding the variance* and *gaining perspective* helped participants to be non-judgmental so that they could choose their approach to clients who hoard or help clients to retain housing even if they did not live there initially. By considering these concepts within the client context and being aware of their own perspectives, the participants learned about their own biases, which helped them to be non-judgmental and empathic in supporting their clients to maintain housing.

Reassessing.

The third subcategory is multi-layered and includes a reassessment of the client, their housing situation, and the team's perspective. The strategies used in the provision of support to reconcile the variance are continually reassessed. Reassessing includes *re-evaluating the team approach* and continuing to learn.

Re-evaluating the team approach. Supportive strategies require reassessment in response to change, and the teams learn from both successes and failures. This reassessment affords new learning and insights by both supplying new information and reiterating the actions of Learning How. As the participants learned more about the clients, they began to examine their perspectives and approaches as a team. Dana explained:

> It feels like to me constantly negotiating and what I mean by that is -- sometimes what we might think is best for someone isn't necessarily what they think [is best for them] right? So we're always talking about it [in our team] and, adjusting our approach to things and adjusting, I don't know, everything. -- I feel like, in the years that I've worked with ACT, that I'm constantly worrying about the people that I work with and about what is really best for them and -- so being flexible and not being attached to the outcome.

This participant was aware that what the team perceives best for the client is not always what the client believes is best for her or him. New understanding and perspectives require the re-evaluation and adjustment of the team's approach (*re-evaluating the team approach*) so that it respects the client's choice, even if the team members are worried about the outcome. Dana identified the need for the team to respect the client's choice and be willing to re-evaluate and shift their perspective to adjust to the client's needs.

However, Dana also identified the struggle by the team members to ameliorate and/or manage both their tendency toward being paternalistic or, as two participants said, "maternalistic," and the belief that they know what is best for the client. One participant spoke of the team's need to "figure out what the client needs versus what the client wants."

Another participant identified that some clients “lacked self-determination and did not know what their needs were.” This participant went on to say that he “wished the client did know and could tell the team.” The participants described that in care planning, they worked with the client to develop client-defined achievable goals, and they were aware of the client’s interests.

The element of client choice was removed when the team made best-interest decisions in circumstances where the teams determined that the client did not know what they needed or what was best for them. The tendency in these situations was to manage and resolve the problem as a team instead of working with the client to determine her or his own solution. This practice emerged in a discussion about providing housing when the client wanted to live in independent housing (market rental), but the team perceived that the client needed housing with some form of on-site support. Inherent in Learning How is the balancing of client autonomy with the perceived need for the team to control for the best client outcome, and balancing maternalism or paternalism with the team’s goal of working toward the client’s self-determination. The circumstances that lead to *reassessing* establish that Learning How is a continuous iterative process.

Continuing to learn. Learning How is a continuous and iterative process in which team members provide client support and re-evaluate in order to meet the desired goal of stabilising their clients in housing. When they talked about stabilising the client in housing, the participants spoke of “going back to the drawing board,” “figuring it out,” and “establishing the client’s baseline.” The participants explained that for a variety of reasons, some clients might lose their housing and hence need to be re-housed: “Clients may take three or four tries before they get it.” In this case, “getting it” means that the clients understand and comply with the housing rules, such as no smoking or substance use in the building, and restrictions on having guests. Other participants described working with "clients we haven't figured out yet" or of "going back to the drawing board," and that the process of housing and re-housing a client is an "intuitive process of trial and error." Therefore the participants viewed the loss of housing as part of the process of *matching and fitting*: the team rehouses the client and tries again, perhaps using different supportive strategies, such as providing more or less structure within the housing or developing a behavioural contract, which is discussed further in Reinforcing Capacity. The participants continue to learn how to support the client, and they have to readjust their strategies because engaging in process of support is one of trial and error.

As discussed earlier, the team reviews and reassesses what has worked in the past in the client's housing situation as well as what has not worked for the client. In these situations, Learning How could mean identifying more appropriate housing for the client, such as living independently in market rental housing or low barrier housing. The need to review strategies highlights the fact that the process of Learning How is experiential and continuous and that it takes time for both the team and the client to learn the strategies of support that are appropriate to the client's housing situation.

Hence, both the team and the client are in continuous transition. Kelly provided the analogy of a journey. She envisaged the ACT team as "traveling with the clients through their mental health and addictions ups and downs." Kelly further explained that this shared journey of the ACT team and the client could be influenced by the client's position on their own mental health spectrum or their cycle of substance use. This means that the team members constantly reassess the client in relation to their mental health and substance use. Kelly and other participants valued keeping abreast of how the client's situation changed by "knowing the client's baseline," and they used phrases such as "establishing the client's baseline," learning over time the client's "cycle of substance use," and "patterns of substance use." It is clear that Learning How takes time; it is a process of trial and error where both the participant and the client are in transition. *Re-evaluating the team approach* and *continuing to learn* as the client's life circumstances change and situations arise within the client housing make Learning How a dynamic and iterative process.

Summary of Learning How

When the ACT teams work with a client, they engage in Learning How. They do this in three main steps. First, they *learn about the client*. They use this knowledge to *understand the variance* between the client's capabilities and the conditions imposed by societal norms and being a tenant. They then continually *reassess* and re-learn as conditions change.

Learning about the client includes *assessing the client*, evaluation of substance use, rule following, income, social and health history, and motivation to engage with the ACT team. All these factors influence the ACT team's support strategies. The assessment is used to *match and fit* the client to housing and support, whether for specific housing needs, support strategies, or eligibility for various housing types and programs. This fit might be poor because of the scarcity of different housing options and the complexity of the client's situation. Lastly, the assessment is used to help *predict potential problems,* which leads to the next phase, *understanding variance*.

In this next stage, the team *identifies factors that widen the variance* by understanding the client's experiences of and history of homelessness. By *gaining perspective,* the ACT teams try to understand how the client will engage in or transition to their new housing.

The elements of *assessing the client* and *understanding the variance* evolve concurrently as both the client and the housing situations change. This leads to a continuous reassessment. The team *re-evaluates their approach* by taking into account client choice, their own struggles with paternalism and maternalism, and even the removal of choice. Over time, they *continue to learn*, sometimes starting again, or re-evaluating the client's baseline.

Throughout this process, the team matches and fits the client with appropriate housing and support. I will now discuss the next category of the grounded theory, Developing a Therapeutic Relationship. The table pertaining to this category and its subcategories is on the next page and precedes the findings within this category.

Table 2: Developing a Therapeutic Relationship		
Developing a Therapeutic Relationship	*Extending an Arm*	*Responding to crisis* Meeting basic needs Stabilizing the client Developing a rapport *Supporting the client* Gathering the small team Coordinating services and support Accompanying through admission process-Reassuring *Assertively engaging* Extending an invitation/Meeting for coffee, Checking in Making twice daily visits Persisting Conditions Involuntary/ Voluntary/Client doesn't want to engage Removing barriers to access to healthcare housing

<table>
<tr><th colspan="3">Table 2: Developing a Therapeutic Relationship</th></tr>
<tr><td></td><td><i>Establishing Credibility</i></td><td><i>Being there for the client</i>
Doing what you said you would do
Doing the little things for the client
Not letting the client down
Advocating
Coming through on the promise
<i>Being there for the long haul</i>
Continuing to support the client who loses their housing and or relapses.
Being there in crisis
<i>Manifesting qualities</i> (all aspects of establishing credibility)
Being nonjudgmental-
Not giving up,
Being optimistic-
Being persistent,
Being client centered,
Being prepared to understand the clients perspective
Believing in the client when they do not believe in themselves.
Being reliable (not letting the client down)
<i>Gaining and Eroding trust</i>
Gaining trust –talking openly/supporting self-care
The client who doesn’t trust
Conditions/circumstances eroding trust
Exerting control/Meting out consequences/Collaborating with the ICS</td></tr>
</table>

Developing a Therapeutic Relationship

Developing a Therapeutic Relationship is an ongoing process that concerns the actions the participants take to foster the clients' confidence that the team members are reliable and act in the client's best interests. In Developing a Therapeutic Relationship*,* the participants engage in *extending an arm* and *establishing credibility*. *Extending an arm* begins when the team reaches out to a client in crisis who may not easily trust others. The initial team-client interaction in the provision of support is the initial stage in Developing the Therapeutic Relationship. *Establishing credibility* is the second step, and it is vital in this process. The team members need to convince the client that they are there for the client because without this belief, the therapeutic relationship cannot continue to develop with trust.

Extending an Arm

When clients are first admitted to the ACT team, they are often in crisis. The team extends a strong supportive arm to pull them out of their crises. In *extending an arm* the participants are *responding to crisis, supporting the client,* and *assertively engaging* the client. At the time of this study, 50% of the clients admitted to the ACT teams were homeless and living in extreme poverty, and many others were unstably housed. The clients were often repeatedly in crisis, and they were frequent users of emergency psychiatric and detoxification services, emergency rooms, and shelters. All clients had problems related to severe mental illness and/or substance use, and most clients experienced complex physical as well as mental health issues in addition to homelessness or housing instability. The participants explained that when clients were admitted to any of the four ACT teams, the initial focus was on helping them meet their basic needs for shelter, safety, clothing, and food. Robin reported:

> When we get the clients [on admission to the team], many are homeless or at risk of being homeless, and they haven't been stabilized in terms of their mental health, and they probably have an addiction and all these things, so everything's very crisis oriented when they come in. Then your main goals are short-term, like [addressing] their immediate needs, such as housing and getting them in to the doctor and getting their meds and -- you know, so I think there's a period of really just meeting short-term immediate needs and stabilizing that person as much as you can, with those things, and then, with that, you're building trust and rapport and engaging them.

Responding to crisis. Robin explained that in addition to ensuring that the client's basic physical needs are met, the team addressed urgent health issues and mental illnesses with the goal of stabilising the client as much as possible. As well as stabilising the clients' mental and physical health, the team also sought to stabilise their housing situation by finding housing or ensuring their existing housing. The actions and interactions of *extending an arm* to provide support in crisis and stabilizing clients provided opportunities to develop the rapport needed to establish the therapeutic relationship. Hence, it is important to begin developing the relationship during the admission process. *Responding to crises* and providing material, practical, and emotional support throughout the admission process are the initial steps in building rapport, trust and the therapeutic relationship. This relationship is required if the participants are to support the client to remain housed.

Supporting the client. I observed that client's admission to the team proceeded rapidly, resembling the admission of an acutely ill person to the emergency department of a hospital. The participants reported that the client's primary support is a small team within the larger team. One person, usually a nurse or a social worker, is the client's clinical lead and co-ordinates care and services. However, no professional role is specific because the team members share many aspects of the work and their roles overlap. The small team supports the client throughout the admission, which includes helping the client navigate the health care system, as well as providing information, reassurance, and counseling when necessary. *Supporting the client* also involves accompanying the client during interviews with the team psychiatrist and other service providers, such as a physician, if it is necessary, and the client permits it. A team member ensures that the client attends appointments on time and accompanies him or her to medical investigations, such as blood work, x-rays, and any other procedures if needed. The team leader or a social worker explains the application processes for monies and housing subsidies. A team member also meets with each client for coffee or a walk to keep abreast of how that client is doing.

Assertively engaging. In this early stage of admission, the engagement with the client is intense. A significant criterion for being admitted to the ACT team is the client's lack of engagement with case management and community services. Admission to the ACT team can be voluntary or involuntary; a client may be living in the community but will be mandated by the Mental Health Act to work with the team. One participant spoke of *assertively engaging* the client, explaining that this could mean seeing the client daily or even twice daily. The team *assertively engages* both voluntary and involuntary clients, taking the initiative to interact with the client and extend invitations to them to meet, to go for a walk, or have coffee. This affords an opportunity for communication. *Assertively engaging* the client in this context is part of the process of *extending an arm* of support. The participants used the words "intensive" and "assertive" interchangeably. However, *assertive engagement* was also discussed in the context of ensuring that the client continued to remain both engaged with the team and housed. One participant described how one client was very reluctant to engage with the team, but the participant continued to knock on the client's door and speak to the client, even if this interaction was brief. The participants identified that trust had to be earned. In clients who do not want to engage with the team and who are inherently distrustful, any movement toward trust can be fragile.

Establishing credibility

Establishing credibility is also important in Developing a Therapeutic Relationship. Team members must demonstrate *being there for the client,* and *being here for the long haul.* The participants were aware that because clients had been let down many times in their lives, they have difficulty trusting others. One participant flatly stated that trust had to be earned. For example, if a team member promised to obtain blood results and explain them, acquire equipment such as furniture or a walking aid, meet for coffee, or arrange transportation to the community garden, then he or she must fulfil this obligation. The participants discussed their efforts to ensure punctuality and their belief in the importance of not letting clients down. The participants also stated that they would become stressed if they were not able to do what they said they would do. By making every effort to follow through on promises to the client, the team members indicated that they were cognizant of the importance of creating and maintaining credibility in the relationship.

For these participants, the key factor was delivering on promises and respecting the client, even if the latter missed appointments, and the team member's agenda was very full. This demonstrated that the team members were committed to the client relationship and took it seriously.

Being there for the client. *Being there for the client* was described variously by the participants, including “doing the little things for the client,” “really listening to the client,” “being available in a time of crisis,” and “advocating for the client” to demonstrate that “you are on their side.” It also entailed “following through on commitments,” “not letting the client down,” and “doing what you said you would do.”

Dana identified the importance of demonstrating to the client that the team members were there for them:

> I think it’s that therapeutic relationship you have with a client, is that trust that’s built up with you and them over time and then, you know, you had -- sort of get advocate [sic] with the housing. So, I mean, if you’re going to a housing meeting, you’re not going in there to give the client a telling off. You’re going in there to help them maintain their housing. And, you know, it is definitely that -- the relationship that’s built up over time with the client that keeps that whole thing going.

Dana noted that the team members advocate for the client, working to resolve issues that arise within their housing situation and demonstrating that they are there to help and support, thus establishing credibility. *Establishing credibility* over time is essential to developing trust in the therapeutic relationship. *Being there for the client* is one component of establishing credibility; another is demonstrating to the client that the team is “here for the long haul*” (being here for the long haul)*

Being there for the long haul. Once the client is engaged, the team provides long-term support. Ray spoke of *being here for the long haul as* part of building the relationship and establishing trust:

> Just the unwritten unspoken sense of security and we’re there for you. Even if you do get admitted to hospital, once you’ve been admitted to us, once we are engaged, we are working together, we’re here for the long haul.

Ray referred to a situation in which a client had decompensated in mental health, had relapsed, used substances, lost housing, and was even admitted to hospital to be stabilized. This client had a pattern of substance use-related behavioural issues and housing loss. By *being here for the long haul,* team members again demonstrated their commitment to supporting the client. By learning that the team would continue to work with them, the clients could maintain trust even when they relapsed or engaged in behaviours that were problematic or excluded them from housing.

Manifesting Qualities. The participants identified many qualities as being important to *establishing credibility* although discussed in this context these qualities were seen by the participants as important to Developing a Therapeutic Relationship and came to the forefront in the participants discussions of *being there for the client* and *being there for the long haul* and *gaining trust.* The participants spoke of the importance of manifesting the following qualities *[manifesting qualities]* of being non-judgmental, optimistic, believing in the client. Participants specifically spoke of being non judgemental of clients when they relapsed and not giving up on them. The quality of "being non-judgmental" was deemed necessary to maintain the therapeutic relationship. One participant talked about not giving up on her clients, even if they had given up on themselves. Most participants expressed the optimistic belief that they could do something to promote their clients' health and/or recovery. The participants expressed the general belief that there was always some kind of progress over time, even if it was slight. Regarding the situation where a client relapsed and lost housing, the participant said, "We are saying to the client 'we are still there for you'." ACT team members followed up the client in hospital, advocated for them, and participated in planning the discharge. The participants also ensured that the client had clinical support, retained housing during admission, and gained access to housing upon discharge. Their responsibility to the client was not relinquished because the client was admitted to hospital.

Being here for the long haul was demonstrated by not giving up on the clients, even if the clients gave up on themselves, remaining non-judgmental when the client relapsed and/or lost housing, and supporting the client throughout hospitalization. Relapse did not mean discharge from the team, and the teams worked to prevent the loss of housing during the client's absence. These qualities enhance and help build the therapeutic relationship, which is necessary in the work the participants do to support the client to remain housed. These qualities are also important for the participants to provide ongoing support throughout housing loss and relapse.

Gaining and eroding trust. The participants reported that they developed a therapeutic relationship with their clients. They sought to earn the trust of their clients. Many participants believed that they had established a positive therapeutic relationship based on trust. This was expressed in the level of comfort in conversation between the participants and the client and the client's ability to talk openly about their substance use, their current symptoms of mental illness, and any life issues they were experiencing. I witnessed these interactions during my shadow shifts.

Conversely, one participant explained that one client would not talk about substance use, and clearly did not want the team involved in his or her recovery process in a community-based treatment program. Some clients do not easily engage, such as the client mentioned above who did not want to speak to the team member about recovery.

The team's *extending an arm* by *assertively engaging the client* and their sensitivity to the need to *establish credibility* underline the team members' shared understanding of the importance of trust in the relationship. Lee, like Dana, observed that "developing a relationship takes time" The participants reiterated their views that because some clients do not trust easily, trust has to be earned and credibility must be established.

Three participants discussed the factors that they believed could erode trust, which I call stressors. These stressors created tension within the therapeutic relationship as the team worked with their clients to maintain housing. The participants used the term "eroding trust" and described trust within the therapeutic relationship as "tenuous" and the relationship as "full of hills and valleys." The stressors included "meting out consequences" to the client and "collaborating with the ICS."

Some examples of "meting out consequences" are as follows: removing clients from their housing for a short period (e.g., four to eight hours) at the request of the housing staff because of the client's infraction of a condition set by them; dealing with an event to which the team responded much later. The participants identified these as circumstances that eroded their trusting relationship with the client. Another source of relationship stress occurs when the client has to be evicted (or "de-housed") by the team for safety reasons and removed from housing to a shelter. A third source of tension noted by the participants was accompanying the client to speak with the judge in the integrated court system (ICS). The team collaborated in planning the conditions the client had to meet for community living and ensuring that these conditions were met. In situations, such as when the participants removed the client from her or his housing for a period or when the participants and client met with the judge, a third party was present to enforce the conditions; however, the team had to mete out the consequences. These situations were of concern to some participants. Because of their backgrounds and lifestyles, many clients often found it very difficult to trust others and form relationships. Although it is necessary to develop a therapeutic relationship, the participants also must enforce conditions and exert control over the clients' lives. This tension is also created when the teams have limited choices and must make best-interest decisions behalf of clients, with respect to housing. The participants identified these as stressors in Developing a Therapeutic Relationship, which could erode the relationship.

The participants identified that a desired outcome of developing the therapeutic relationship is that clients may seek the team's support in taking care of themselves. Lee perceived that once clients were living in a stable environment and were not in crisis, they could begin to contemplate taking care of themselves. Lee explained she had to be able to recognize the indicators of this stage of change, especially the signs of contemplation and pre-contemplation (i.e., identifying contemplative stages).

> As the client gets more stable they become more contemplative and all of those things. When the client is not in crisis they start to move through their own contemplative stages... and focus on self-care, perhaps not addictions as you do not want to address that right away and start telling them how they should stop using drugs or drinking!...Once you have that relationship, then you can start to try and approach these more difficult subjects, such as past trauma, the need for counseling or their addiction.

The participants reported that seeking help could be an indicator that the client was beginning to trust others, had improved self-esteem, and was moving forward in recovery. Based on the evolving relationship and the greater stability in the client's life, the ACT team could then begin to support the client in attending to health and life issues. A caveat is that if the teams used a harm-reduction (HR) focus, they would talk about harm reduction early in the relationship. By not talking about substance use, they would be contributing to the risks of harm. Clients who gain some stability in their lives because of housing stability and ongoing support of the team, and who trust the team in seeking help, are more likely to remain housed. One participant identified two clients for whom this was the case, explaining that both clients had been unstably housed for many years.

Summary of Developing a Therapeutic Relationship

In order for the team members to support their clients to maintain housing, they need to Develop a Therapeutic Relationship. They do this in two ways. First, they *extend an arm,* and then they seek to *establish their credibility* with the client. In *extending an arm,* they reach out to clients, who are often in crisis, by meeting their basic needs for food and clothing and shelter. They team also stabilizes clients by attending to their urgent physical and mental health needs. The participants described accompanying and *supporting the client* through an intense admission process. The team *assertively engages* their clients checking them once or twice daily and meeting them for coffee. Through the activities in *extending an arm,* the team begins to develop the therapeutic relationship required to support clients to remain housed.

The participants also identified that they have to *establish their credibility* with the client. They *establish credibility* by *being there for the client* and basically demonstrating that they are reliable. Participants used the following terms: "doing what they said they would do", "not letting the client down," and "advocating for the client." The therapeutic relationship is further promoted when participants demonstrate to the clients that the team would continue to support them despite relapses and loss of housing because of hospitalization. Participants described this *as being there for the long haul.* The qualities identified in the participants and the team to gain the clients' trust were as follows: being nonjudgmental, remaining optimistic, being persistent, being client centered, being prepared to understand the client's perspective (understanding the client's) perspective, and believing in clients even when the latter did not believe in themselves.

The participants discussed situations that they believed could erode and create tension in the therapeutic relationship, including meting out consequences to the client and collaborating with the ICS. These participants had to justify their actions to clients as they enforced conditions and control over their lives.

However, once the relationship was well established, the team members could begin identifying contemplative stages and approaching difficult subjects. Life-controlling experiences, such as substance use and trauma, could only be broached once the trusting relationship was established. Developing a Therapeutic Relationship occurs concurrently with Learning How, by which the team can support the client and reconcile the variance in order to maintain housing. Learning How and Reinforcing Capacity cannot take place without the Developing a Therapeutic Relationship. The strategies used to reconcile the variance are described in Reinforcing Capacity. Learning How provides the team with the information that informs the strategies used in Reinforcing Capacity. Reinforcing Capacity is the core category of this grounded theory.

Reinforcing Capacity

In this section, I explore how the ACT teams seek to reconcile the variance among the characteristics of clients that make them vulnerable to housing loss, the factors that influence clients' capacities, and the conditions and expectations that clients have to meet in their housing situation. In developing this central category of the grounded theory, I found that Reinforcing Capacity concerns supporting the client and balancing the interests of the client, housing staff or landlord, other tenants, and the team. Prior to presenting the table of categories and subcategories and discussing the findings within Reinforcing Capacity, I discuss how this core category of how ACT teams support clients to maintain housing relates to all other categories

Reinforcing Capacity is the core category in the theoretical model of the ACT teams' support of vulnerable clients to maintain housing. Reinforcing Capacity relates to and links all major categories (see Figure 1). To reinforce the capacity of the client to remain housed, the teams engage in the reiterative and continuous process of Learning How as the team responds to changes in the client and in the housing situation. Thus, Learning How often necessitates a review of the strategies used in Reinforcing Capacity. The actions taken in the process of Learning How cannot be effective unless the teams Developing a Therapeutic

Relationship with clients. Moreover, relationship building continues throughout Reinforcing Capacity concurrently with Learning How. Developing a Therapeutic Relationship and Learning How are also ongoing throughout Negotiating Re-entry and Enforcing Conditions.

For approximately one third of clients, the team works with the judge in the ICS (Enforcing Conditions). The clients are compelled to meet the conditions set for community living (e.g., where the client resides and/or with whom they may associate). The judge seeks the team's input in setting these conditions and observes whether clients meet them. The team's experience with the strategies used in Reinforcing Capacity and the knowledge gained in Learning How can inform the conditions set by the ICS. Regardless of whether housing is maintained, the team is Negotiating the client's Re-entry to housing, or collaborating with ICS, the team members are continuously Learning How to support the client and Developing a Therapeutic Relationship. Therefore, all activities support Reinforcing the client's Capacity to remain housed. I will now discuss the findings within the core category. Table 3 below shows this category and its subcategories, and it precedes the findings within this category.

Table 3: Reinforcing Capacity

Major Category &	Subcategories	Types/Circumstances/Conditions/
Reinforcing Capacity	*Interacting therapeutically*	*Managing Medications* Stabilizing the client's mental illness Facilitating therapeutic contact Ensuring compliance Maximizing time Balancing Priorities distance monitoring Providing Structure (types) Banning/limiting guests Secure controlled font door Video surveillance/sign in Banning the guest of visitor Educating to socialize outside the building Making a best interest decision for the client Placing the client on a program(behavioral contract) Influencing conditions Needing boundaries (client has difficulty setting boundaries) Protecting the client (vulnerable) To protect tenants and staff (safety) Team perceive client needs to earn the right to have guests Conditions of being housed (set by the housing agency) Placing the client where housing is available Consequences Promoting housing stability/housing tenure Decreasing choice/increasing control. Struggling with being maternalistic/paternalistic Straining the tripartite relationship Creating a barrier to housing retention Reducing Harm Stopping trouble before it starts Labeling client/guest Creating tension in the tripartite relationship Eliminating choice/increasing control *Managing money* Reducing harm\ability to purchase substances Conditions Being constrained in HR practices Using Motivational Interviewing techniques *Educating the client* Explaining the rules Coaching the client Providing emotional support Improving the client communication skills Conditions/Circumstances Lacks experience of being housed Helping the client meet the norm Client fears failure Insulating the client

Table 3: Reinforcing Capacity		
	Maintaining relationships	*Becoming Intermediaries* Deflecting tension Becoming a sounding board, deescalating Supporting the landlord Being sensitive to the position of the landlord and housing staff Being a relationship counselor, diplomat, and peacekeeper. Insulating the client Circumstances Working with clients who are considered problematic; highest fliers Tensions between the clients and the landlord/housing staff. Angry exchanges between the landlord/ housing staff and client- “clashes' Deflecting-stopping the landlord “going after the client” Client is being evicted -being diplomatic Consequences Keeping the door open (for rehousing Client or other clients). Mending relationships Preventing deterioration in the relationship Preventing loss of housing

Table 3: Reinforcing Capacity		
	Collaborating	*Communicating*
		Maintaining communication (ongoing communication)
		Attending regular interagency meetings,
		Strategizing
		Identifying/ focusing on problems, Collaboratively problem solving
		Consequences
		Developing a shared plan, working toward a shared goal
		Solving problems /working together
		Maximally supporting the client
		Retaining the clients housing
		Circumstances
		Managing problems and clients
		Conditions for Collaborating effectively
		Focusing on the problem
		Developing solutions together
		Having strong relationships between the team and housing staff
		Willingness to work together
		Barriers to Collaborating:
		Lack of interagency communication
		Unclear methods of communication
		Hierarchal divide
		Differing priorities
		Differing perceptions of safety
		Conflicting roles
		Circumstances
		Consequences
		Lack of collaboration
		Loss of housing
	Containing chaos	*Keeping everyone happy*
		Containing behavior
		Reducing impact on others
		Being client centered & creative
		Focusing on problem solving.
		Circumstances
		Clients disturbing others

Table 3: Reinforcing Capacity		
	Juggling the variance	*Negotiating with the client* Encouraging client to make concession *Negotiating with housing staff* Brokering deal between client and housing staff *Bargaining and buying time* Providing interim housing Getting and extension Negotiating terms of lease renewal Advocating; highlighting progress; Highlighting strengths; emphasizing progress

As Table 3 shows, in Reinforcing the client's Capacity to remain housed, the participants engage in five interrelated processes that form the subcategories of this process. The interrelated processes are *interacting therapeutically, maintaining relationships, collaborating, containing chaos, and juggling the variance*. I will now discuss each of these subcategories and how they relate to the core category, and contribute to supporting clients to remain housed.

Interacting Therapeutically

In my observations during shadow shifts, *managing medications* is done not only in administering medications but also in order to ensure frequent, even daily, therapeutic contact with the client. During these visits, I noticed that the participants assessed the client, provided support as needed, and responded to clinical concerns, such as helping the client manage symptoms of mental illness or setting boundaries with other tenants who persistently borrowed money, food, or cigarettes, and did not return them. In my observation, the participants' interactions with the client were kind and friendly. Meeting with the client was an opportunity to develop the therapeutic relationship. The participants expressed that some clients, particularly those who live with severe mental illness, tend to isolate when they are housed, which can lead to the deterioration of mental health. In maintaining contact with such clients, the team encourages and facilitates their engagement in activities by providing support as needed, thus reinforcing their capacity to remain housed.

The participants who worked on ACT teams believed that *stabilizing* the client's mental illness through medication management, especially in the case of clients with severe mental illness, was essential to keeping those clients housed. The participants identified situations where the client's housing tenure was at risk because landlords did not understand or were fearful of a client's unpredictable or unusual behaviour. The relationship between the client's housing and the support staff can become strained, and this lack of understanding manifests in subtle ways in what few team participants described as personality clashes and arguments. Arguments and clashes are not necessarily related to whether a client takes medication or not. Although many housing staff are trained and experienced in working with clients who live with mental health and addictions, many staff in the region are not. Although the teams take an individualist approach in supporting the client, such as *stabilizing* the clients' mental illness, at some housing sites, there is clearly a need for the education of the housing staff in this respect.

All participants were involved in administering medication and/or observing clients take it, often visiting once or twice daily to give the client antipsychotic medications and to monitor him or her. In three of the teams, some clients came to the ACT team's office to receive their medication and some also received their monetary allowance for the day or week. As part of the money-management program discussed below, medication compliance is linked with the client's allowance. Because the office of the fourth team was not in a central location, their clients did not "drop in" to collect medications or monies, but were seen by the team members in the community setting.

Administering medication daily to clients who lived out of town was problematic because of commuting and traffic congestion. However, the teams believed that it was important to monitor the administration of medication and had developed alternate methods. For example, the participants telephoned two clients to support medication administration. In one case, a second person was with the client to ensure that the medication was taken, and the phone call served to both remind the client to take the medication and obtain confirmation from the accompanying person. In another case, the client lived far from town and was expected to take the medication during the team member's phone call. The participant explained that four clients could be seen during the time it took to commute to and from the out-of-town client's residence. In all cases, the participants worked at maximizing their time and balancing priorities.

From the participants' perspective, "distance monitoring" does not always work. One out-of-town client had missed paying rent on more than one occasion and was consequently evicted. The participant believed that the client had increased his substance use and spent his allowance cheques on substances. The team were concerned that the client could no longer access the support services available in town, and they were planning to re-locate the evicted client back to town to be closer to services and to the team.

Clearly, the ACT teams believed that stabilizing the client through medication management Reinforced the client's Capacity to remain housed. Frequent contact with the clients afforded opportunities for assessment and providing client support, thus helping to Develop the Therapeutic Relationship. The participants believed that engagement with the team and taking medication regularly, coupled with the provision of structure, led to a higher number of positive client outcomes. Home visits were also considered a therapeutic strategy and part of the team's process of providing support to retain housing.

In the case described above, based on costs of both money and time, being housed out of town was perceived as a potential barrier to the provision of supervision and support because it reduced the teams' overall ability to support the client to remain housed. These realities limited the client's choice in housing, and the location of the client's housing became directly influenced by the ability of the team to provide support. Non-payment of rent also reduced the client's opportunity to continue living in the apartment building and to obtain a favourable reference from the landlord, which created a barrier to accessing further housing. The client thus faced the same consequences that any renter would. In this situation, there is no contingency for rapid re-housing. In contrast, the Pathways to Housing First program enables the quick provision of housing (Tsemberis, 2010, p. 75).

Providing structure. The second strategy in interacting therapeutically, *providing structure,* ensures that some external structure is provided to the client by placing constraints on the housing context. The most complex, contentious, and multifaceted concern of both the teams and the housing staff was the issue of guests, which were considered “the number one reason” clients lost their housing. The participants discussed that either the team, the housing agency staff, or both set parameters regarding guests, including the number a client could have, when guests could visit (daytime, not late evening), or whether clients could even have guests. The decisions to set these parameters were based on the team members’ or housing staff’s perception that the client was “vulnerable.” An example is a client who has “difficulty setting boundaries” on the behaviour of his guests or who allows such guests into his home. Disruptive behaviour by a guest or tenant can lead to eviction. These behaviours include engaging in illegal activities, such as selling drugs and noisy parties. Providing this type of controlling structure necessitates restricting and monitoring a client who is perceived as vulnerable, as well as their guests, in order to protect both the client and other tenants. The team members also work with the clients to help them understand the responsibilities of tenancy. Hence, they support the clients to maintain their housing.

Banning clients from having guests was seen as both protecting the client and promoting their housing tenure, thus pre-empting the loss of housing caused by the poor behaviour of guests. If the client is to retain their housing, they need to comply with these restrictions; monitoring and control were perceived as ways of promoting compliance. At most housing sites, the comings and goings of tenants and guests were monitored, and surveillance was a feature at some housing sites with supportive staff. The entrance doors are kept locked, and there is a security camera. Staff members check and admit visitors. The participants argued that surveillance affords protection for the client and other tenants. At other housing sites, the person at the front desk, which all visitors must pass, monitors surveillance cameras. In some places, guests or visitors have to sign in. At other sites, I saw photographs of people “banned” from the building. These were posted out of the sight of non-staff on the wall behind the desk.

Surveillance concerns controlling the entrance to the building, keeping people housed, keeping their unwanted guests out, and protecting other tenants. The extent of surveillance underscores the degree of oversight, restriction, and control under which some ACT clients live. In this region, where there is a lack of affordable rental housing and landlords are less willing to rent to ACT clients who were formerly homeless, accommodation for ACT clients is more readily available at supported and staffed housing sites. Supported housing sites have greater surveillance and restrictive rules, especially with respect to guests. This environment is considered beneficial for some clients, but in some cases participants question the suitability of this inflexible structure although they are aware that there is little other housing available. Clients have limited choices with regard to their housing placement, and the teams have very little say in client placement once they are referred to the central housing placement agency. Choice is one of the underpinning philosophies of HF and a contributing factor to housing retention. Lack of choice and placement in an environment that does not meet the clients’ needs could lead to housing instability. Moreover, tightening control and surveillance may be a barrier to housing retention. Some participants expressed that they would like to work with those who establish the rules, and they would like more say in their clients’ housing placements. This raises the following question: Who benefits from this type of arrangement? It is believed that some clients benefit and others are disadvantaged.

One participant said that “guests are a privilege, not a right,” and this privilege must be earned. Hence, clients need to “demonstrate that they are responsible,” that is, responsible enough to have guests. In some housing situations, the restriction of guest privileges is a condition of tenancy and is also framed as a safety concern of other tenants and staff. Although some participants argued that their “clients only have to comply with the rules of the Residential Tenancy Act like everyone else,” other participants maintained that ACT clients often “have more rules to contend with than you or I would in our own home.” Examples are restrictions on guests, no smoking in the client’s room, and the need to “earn the right” to have guests. One participant was concerned that her client “could not comply with having a one-guest restriction, [so] how [would she] comply with the now imposed no-guest rule?” Inflexible rules restricting guests were at times considered unrealistic and an actual barrier to some clients in remaining housed. Alternatively, some clients were assessed as needing to live in controlled environments.

The participants provided examples of client vulnerability, such as being taken advantage of by others, being “lonely,” or unable to say no to “friends.” On occasion, these “friends” were seen as “drug dealers,” and in the case of one client, “the guests disrupted the entire building.” These reports of using rules as part of a structure to protect clients and other tenants from disruptive or dangerous “guests” were commonplace. Although the rationales of protection, safety, and maintenance of housing tenure appear legitimate, the overemphasis on collective disruptive situations leads to a highly controlling structure with inflexible rules for all tenants, not only ACT clients.

Though not all guests are drug dealers or predators, and not all tenants are vulnerable, the issue of "safety" is addressed by a blanket policy: the client is banned from having guests, and guests entering the building are monitored and controlled. The participants stated that in order to remain housed, some clients had to "learn to socialize outside of their housing." Some clients have very little recourse regarding the restrictions that are imposed on them. Participants identify that in some cases, the limited or no-guest rule is applied by housing staff and in other cases by the ACT team. Hence, although the ACT teams have to function paternalistically in regulating the client's behaviour in order to retain housing, the participants sometimes did not agree with the imposition of the no- or restricted-guest rule.

Guest issues cause tension in the relationships between the client and housing staff and between the client and the ACT team. Rules about guests were also instituted as pre-emptive measures to "stop trouble before it starts" when either the client or their guests were known to be or labelled as troublesome in previous housing. One example related by a participant involved a client who was placed on what housing staff called "a program" in which guests were prohibited. The participant explained that the client "like[d] to have friends over" and the ACT team considered it "important and healthy to have friends over." Unfortunately, the client's friends were described by the participant as people with "a bit of a reputation within the mental health community." Because these friends "had been in trouble before and gained a reputation," they were not allowed in the building. The program restricted guests, and the client had to comply in order to remain housed. Although the team members believed the client would benefit from having guests, even those with a poor reputation, the client had no option regarding being placed in the program and having no recourse. Additionally, the client's guests were now labelled in the community as problematic; their reputation preceded them with no opportunity for them to demonstrate change. In this situation, the client's voice was unheard. The participants expressed that the attitude is that rules are rules, and decisions are final.

This situation demonstrates the inequality and the lack of partnership between the housing staff client and the ACT team. *Providing structure* concerns supporting the client to live within the rules of the Residential Tenancy Act and minimizing the risk of eviction, thus Reinforcing the client's Capacity to remain housed. In addition, some types of housing with on-site staff are more restrictive than others with regard to guests. For example, at staffed housing sites, clients and their behaviour are monitored, and in other cases, observation is increased through video surveillance. It is worthwhile considering whether this type of housing is suitable for clients, as well as who benefits from this type of housing. Nevertheless, clients could be placed in this type of housing through the centralized placement system because housing options, such as rental apartments, where they could live independently, are limited.

The pre-emptive imposition of rules is rooted in the treatment model of care of clients with mental illness in the community, which assumes that individual client–tenants are incapable of making choices and decisions about their social relationships. Therefore, those social relationships have to be externally controlled. This assumption is problematic because its effect is to reduce the element of choice in clients' lives, and it further stigmatizes people with mental illness (Denton & Bianco, 2001) and/or a history of substance use. ACT clients obtain access to housing because of their health and social history. At the time of this study, approximately 32% were placed in housing sites with clinical staff, such as nurses, and roughly another 25% were at housing sites where only some staff were trained in mental health and addictions. Although the participants described situations when their relationships with housing staff were collegial and worked well, they also discussed areas of tension.

Two participants explained that they were called by the staff at housing sites in order to mete out the negative consequences to clients for their infringement of housing rules. The participants stated the belief that responding to rules set by a third party was detrimental to the therapeutic relationship that they were attempting to build with the client. Hence, the undue emphasis on control at supportive housing sites could be counterproductive, resulting at the most in the loss of housing (Allen, 2003; Wong et al., 2008) and at the least in straining the relationship between the housing provider and the client (Wong et al., 2008). In general, the participants perceived house rules as homogenous and not client-centred, which led to tension.

The tensions caused by the limitations on guests are the topic of on-going discussion between the team and the client, the client and the housing staff, and the team and the housing staff. The team must work with the client to satisfy the conditions of being housed, which the housing staff oversee. This involves placing the client in a program and reiterating the rules *(educating the client)* that are necessary to keep the client housed. The client has little or no choice: he or she must either comply or lose the housing. These rules and constraints amount to paternalistic control, which was seen by some participants as adhering to the treatment model for mental health housing. They expressed that although it was suitable in the case of some clients, it did not fit the needs or capabilities of many others, particularly those whose primary diagnosis was not severe mental illness. I will discuss perceived lack of fit in the final chapter.

Furthermore, the pre-emptive restriction of guests and the requirement of earning the right to entertain does not fit the HF model, which states that rules extraneous to the Residential Tenancy Act are not to be applied to the client (Tsemberis, 2010). These policies are clearly contrary to the philosophy of the HF model, to which the region claims to subscribe. Indeed, inflexible rules that are extraneous to the Residential Tenancy Act can in fact become barriers to retaining housing. The topic of restricting guests is germane to *providing structure*, the circumstances in which structure is needed, and the types of structure. *Providing structure*, in some cases, negatively affects *interacting therapeutically* to support the client in remaining housed. However, structure, as discussed by the participants, can be both supportive and restrictive. It is a matter of learning the best approach to support the client. However, in some cases, the participants have to work with clients to maintain housing within a restrictive structure. The structure promoted by the treatment model eliminates choice and the opportunity for self-determination. These responses are prescriptive, enforce compliance, and do not fit with the philosophy of motivational interviewing (MI) ((Manthey, Knowles, Asher, & Wahab, 2011), which the ACT team uses in therapeutic interactions with their clients.

The ACT and the region's HF program are separate. HF provides housing without the expectations of sobriety. The ACT teams support severely mentally ill clients in the community, and many are housed because of the HF initiative. If the ACT teams and the housing programs both applied the HF philosophy in their practice, clients would be more directly involved in setting goals. Furthermore, they would have choices in housing, and rules extraneous to the Residential Tenancy Act would not be enforced as liberally, thus facilitating and promoting housing retention.

Managing money. All four teams use the strategy of money management to structure clients' spending. *Money management* was developed as a structured program to decrease the risk of relapse to serious substance abuse in people with co-occurring severe mental illness and addiction (Ziedonis, 2004; Rosen et al., 2002). The participants described six situations in which money management was used to ensure that "the client has food in the fridge [and] their rent is paid." In the ACT program, because the rent is always paid directly to the housing manager, the client would not lose their housing because of the non-payment of rent, thus supporting the client to remain housed.

Chris identified other benefits of the money management program:

> Generally, we get the client on board with [money management] and we just say, "Okay, here's the consent to remove those monies and have them go directly to your renter [landlord or rental agency]" so they [the client] aren't being responsible to get their support cheque and decide, "Okay, I have

> to take two hundred dollars and give it to my landlord, but I really want to use drugs." Hm. That's a hard place for someone to be in with a whole lot of money.

Other team members also perceived that the client's ability to pay for drugs was constrained by money management.

> We saw the client twice daily to administer his medications and enrolled him in the money management program. The client's income was used to pay rent and he received [an] allotted amount of money for spending. Being on the money management program he was unable to purchase drugs, [and] he also went into [addictions] treatment. From the participants' perspectives, money management ensures that the client does not face the choice between spending on drugs or rent. It therefore helps the client to not losing their housing because of non-payment of rent. The participants also considered money management a harm-reduction strategy.

Reducing harm. The participants viewed *managing money* as *reducing the harm* caused by substance use because it reduced the client's options to spend money on drugs. The participants also identified housing as a harm-reduction (HR) strategy that applied to all aspects of their clients' lives. They expressed that housing provides a stable environment in which clients can work toward recovery. It is a place of safety where clients can keep their harm-reduction supplies. Ray pointed out:

> The client is safe indoors when using drugs as opposed to being on the curb or in an alley, and substances are far less likely to be contaminated, such as when a person uses puddle water to dilute substances. Clients will not develop pneumonia or risk deteriorated health as they would on the street. The client can take antiretroviral medications and cope with their side effects, by having ready access to a bathroom, for example.

Another participant believed that being housed also reduces the client's contacts with police because of both criminal and non-criminal offenses. Loss of housing was clearly seen and referred to by many participants as “pushing clients back into harm.” The provision of housing, client support, and money management are practices that the participants believed to promote housing tenure.

However, these HR strategies, although *reducing harm*, do not embrace the foundational principles of harm reduction. The dominant discourse in the region and these ACT teams concerns recovery, not HR. The actions taken in the case of some clients reinforce control by limiting the client’s options to spend the money obtained from the ministry on substances. This raises the question of whether clients could circumvent these actions by panhandling, petty theft, or prostitution to gain money for drug use. However, this area was not investigated during the course of the present study. Furthermore, it has not been discussed in the literature relating to money management programs, and therefore warrants further research.

Furthermore, the focus on recovery and money management to restrict the client’s ability to purchase drugs is problematic because the goal of HR is to prevent direct harm from substance use, not to enforce abstinence. In these instances, clients’ goals related to substance use become program-defined instead of client-defined, which does not fit with the principles and practice of MI. It is also questionable that clients would openly talk about their substance use if they were continuing to use. Housing is harm reduction in terms of preventing harm from substance use, which could incur if the client was homeless. However, the participants did not discuss other strategies to prevent the harm caused by drug use, such as the provision of supplies or education on safe drug use. Although the teams addressed broad aspects of harm reduction concerning substance use, they did not necessarily practice harm reduction to its fullest extent.

Because I was curious, I asked the participants to tell me more about their harm reduction practices and perspectives. Three participants discussed their harm reduction actions and two reported being dissuaded by ACT team managers from practicing harm reduction to its fullest extent. Although participants took “sharps” containers to clients’ homes or removed full sharps containers for incineration, they did not provide clean needles or education about safe injection and vein maintenance. I was told that if a client had an abscess and needed education and treatment, she or he would be referred to a nurse practitioner. The participants reported being told that they could not provide clean needles or assist clients in purchasing safer options for alcohol consumption. It was not clear whether this was a written agency policy, however, it was clear that the participants harm reduction practices were constrained. They provided examples of client behaviour for which simple harm reduction strategies could have a significant health benefit. For example, one diabetic client drank alcoholic beverages with a high sugar content, and others consumed products containing isopropyl alcohol, methanol, or ethanol in the form of over-the-counter medications and mouthwash. The participants who discussed this behaviour were frustrated about not being able to practice harm reduction to its fullest extent. When asked about the provision of harm reduction supplies and the teams’ role in the implementation of harm reduction strategies, I was advised “that it was the job of the ACT managers to take this up with the health authority” because the participant had no control over this decision.

It is clear that the participants were constrained in their practice of harm reduction. Nonetheless, this topic is perhaps contentious, and the constraints seemed to have been generated at the administrative level, over the heads of the ACT managers who implemented the constraints. Because the policies and practices of ACT teams do not fully align with harm reduction philosophy, dissonance in the participant often occurs. Many participants endorsed and valued a harm reduction philosophy but did not have the freedom to apply it in practice because of the constraints caused by local conditions. At least two participants believed that this topic needed to be addressed by their team managers.

My review of the reports on harm reduction services in the region revealed a lack of support by people in the neighbourhoods of the needle exchange and harm reduction services. It also showed that the health authority has been slow to act in providing the service despite strong evidence of the need for this type of health-promoting service. Neighbours acted to have the needle exchange services evicted from the building in which the service was provided. The needle exchange was closed in 2008; it has not been re-opened to date. The area most heavily populated by people who use illicit drugs has been decreed a no-service zone by the health authority. At the time of writing, there was a severe lack of appropriate harm reduction services in both this area and the region. This has led to increases in risky behaviour, such as the reuse of needles, reduced access to health and support services, and thousands of used needles unaccounted for in the community.[2]

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[2] The citation is withheld to protect the identity of the team.

Money management and keeping clients housed were identified by the participants as the most important ways to reduce the harms associated with substance use. The participants reported working with their clients in a non-judgmental way, particularly by using MI techniques to discuss the topic of substance use. Although I am aware that MI techniques are non-confrontational and non-coercive, I did not specifically ask the participants how they used these techniques. However, I noticed that the participants used MI to help clients examine the pros and cons of their behaviour in making choices. Nevertheless, the mandate of the regional ACT teams focuses on recovery and using money management to discourage and control substance use despite the teams' understanding and acceptance that some clients will continue to use drugs. Harm reduction is not practiced to its fullest extent and is not a component of the regional ACT program.

The participants perceived that being housed promotes a client's safety, as well as physical and mental health. Although they mentioned that they practice HR, the teams are considerably constrained, and it is clear that they do not subscribe to the full extent of the harm reduction program as set out by the British Columbia Centre for Disease Control (BCCDC, 2011). This program includes the provision of harm reduction supplies, such as clean crack pipes, needles, syringes, and water, as well as education about harm reduction and safer drug use. The ACT teams are in contact with many of their clients daily and most clients at least weekly. They therefore are aware that many of their clients frequently use substances. It is self-evident that the teams are well placed to provide harm reduction services to their clients. Practicing harm reduction to the fullest extent could promote open and honest discussion by both the client and the team about the client's substance use, thus potentially enhancing the therapeutic relationship and the ability to reinforce the client's capacity to remain housed. Participants emphasised the importance of *educating their client* to support them to remain housed.

Participants identified that *educating the client* about the responsibilities of tenancy, setting boundaries, and being able to say no to unwanted guests could further Reinforce the Capacity of the client to remain housed. One participant offered, "People who have never been housed or haven't lived in housing for years need to learn how to have four walls around them and have a roof over their head." Participants frequently spoke about the importance of educating their clients about what it is like to be housed, explaining that many clients have been homeless for long periods and have adapted to an environment that was described by one participant as "rough and abrasive." Jay's remarks echoed the descriptions of many participants:

> I think when people are moving from not being housed, or only being housed for short periods of time, sometimes there are a lot of parameters in assisted [supported] housing [such as] people need to be in by a certain time, there are rules about guests; guest/no guests, whether or not substance use is allowed. So I think it's helping to educate people about the idea that there are more constraints when you are moving from taking care of your needs on the street, keeping them very basic, to being in a structured set of housing that's going to have expectations of you as a tenant, which might not be something that they're used to, having that additional 'something is required of me by somebody, in order for me to maintain this housing.' So that's a lot of reminding them about how to keep housing. And about the rules and regulations and -- I think it's a big shift for a lot of people.

The participants noted that for some clients who have experienced chronic homelessness, being housed is a “big shift” that places a new set of parameters, responsibilities, and structures on how they are now expected to live. Dana remarked, “The client has more rules to contend with in housing than you or I would have in our own homes.” Dana, Jay, and other participants stated that to keep their housing, clients require education and support to develop a set of skills to meet the expectations of being tenants. Chris observed that because they lack the experience of being housed and are “fearful of failure,” clients require not only education but also emotional support:

> Housing is a responsibility they [the client] have never really experienced ...it’s fearful…they have to step up to the plate and they do not know how.

To reconcile the variance between the client’s capabilities and their characteristics, the team members must educate clients and continue to remind them about specific rules and the expectations that they have to meet to remain housed. Chris described this as “coaching the client.” The participants also observed that in addition to education in communication skills, the clients required emotional support when they encountered new situations.

Dana said that clients need to “learn to talk about what is bothering them instead of acting in an aggressive manner.” Aggression toward housing staff, landlords, or other tenants can lead to loss of tenancy. Dana gave the example of one client who was unable to express what was bothering him. Because of poor coping and communication skills, the client became aggressive. This is a straightforward example of the relationship between the client’s capabilities and characteristics and the vulnerability to housing loss. Because of acculturation to life on the streets and difficulty in communicating, some clients present as rough and aggressive. The participants spoke of clients having poor coping skills, which may be situated in a client's social history and education. One participant identified that clients "cycles" into becoming aggressive in their speech when feeling overwhelmed and unable to communicate, perhaps swearing and raising their voices. Thus, more than education of clients is needed; learning to talk about what is troubling them is not as simple as providing communication tips, especially if there are deeper issues, such as substance abuse and a history of trauma (North, Smith, & Spitznagel, 2006), which can only be worked through when clients are ready.

Dana also observed that some clients do not know what their needs are and lack self-determination or the ability to take control of their life and make decisions. In such cases, the team believed they needed to make best interest decisions for clients. Other participants identified that fear of failure in the housing situation was an issue for some clients, and that many clients have low self-esteem, both of which could exacerbate aggressive behaviour (Salmivalli, 2001). Hence, the understanding, tolerance, patience, and respect of the team are essential. Some participants provided education by involving the client in contentious issues with the landlord or housing agency because they saw it as the team's responsibility to model appropriate interactions. Another participant spoke of helping the client learn that behaviour has consequences:

> I think it's important to have the client involved, learning about those behaviours and—and knowing what those consequences might look like.

The participants used MI strategies to work with the client. They might talk with the client about the possible outcomes of negative behaviours, such as arguing with and shouting at the landlord. They showed how these behaviours could lead to the loss of housing and encouraged the client to let the team speak with the landlord. Some participants reviewed with the client their patterns of prior behaviour and outcomes, and they encouraged and helped him or her to contemplate another course of action.

Educating and reminding the client about house rules is a therapeutic strategy that reinforces the client's capacity to remain housed. However, it is important to recognize that the factors that lead to housing loss are deeply rooted. The participants identified that many of their clients have a history of trauma, low self-esteem, poor education, and live in poverty. The onus in educating the client is on the client to change his or her behaviour. The emphasis is placed on promoting change and controlling behaviour rather than examining the written and unwritten policies (Gomez, Hilario, Corbett, & Weeks, 2007), cultural practices, and philosophies that govern the actions taken by service providers to promote compliance to determine where change is needed and can be promoted in this area. The participants discussed that too many rules could be counterproductive, and they reported that clients lose their housing for contravening overly strict rules about guests. This is of guests is complex and warrants further study from the perspectives of the housing staff and client.

Although housing readiness is not a requirement for access to housing, as discussed by the participants, how the client interacts, communicates, and functions determines how they fit into the housing situation and can ultimately determine whether they can remain housed. The participants identified that more low-barrier housing (LBH) is needed. Participants also discussed that some LBH sites “forgot they were low barrier” and that when the tenants in the housing began to settle, the housing site staff seemed to “raise the bar” of expectations for behaviour because a new norm had been established. This meant that newly admitted ACT clients struggled to meet the new norms.

Because the client was seen as lacking in experience and skill, educating the client was intended to promote change in the client’s behaviour to fit the conditions of housing. The participants described MI as being used to examine the consequences of behaviour and contemplate another course of action. The participants emphasized the role of MI in helping clients to understand consequences, such as loss of housing, and being able to live with structure and regulations. The dimensions of educating the client reinforce the client’s capacity to remain housed. However client education cannot take place in isolation; it needs to be linked with the client’s goals (i.e., it should be client-directed) and his or her motivation to change. It is therefore a process where education and the provision of information does not always result in immediate change.

The subcategory, *interacting therapeutically,* promotes compliance with medication through medication management and stabilizing the mental health of clients who live with severe mental illness. This is perceived to promote housing stability, and therefore Reinforces the Capacity to remain housed. Unfortunately, clients can lose their housing because of behaviour related to mental illness or relapses in sobriety form substance use.

One participant identified that every day is a new day for heir clients and they need to be able to move forwards relapse is inevitable. Participants use MI techniques and they qualities that they manifest as discussed in Developing a Therapeutic Relationship to support their clients when they lose housing. Housing loss could reflect a larger systemic issue related to the regional implementation of HF stigma, the lack of trained housing staff, or landlord education. This indicates the need for a system that considers; relapse as part of the process of recovery, and ensures relapse does not lead to eviction, the system needs to adheres to the principles of the HF model and trains staff in the program philosophy and approaches, including harm reduction.

This system would be one with greater adherence to the HF program model that promotes housing retention in clients who live with severe mental illness and or experience social and physical ill effects of substance use (substance use disorder). However in the studied region there is a gap between the HF policy and community practice in the areas of housing choice, HR practices and (according to the participants descriptions of situations that have led to eviction) and in the development of approaches to ensure relapse does not result in eviction. Watson,Orwat,Wagner, Shuman, &Tolliver (2013).

The subcategory, *interacting therapeutically,* relates to visiting clients to administer medications on a regular basis, which is an opportunity for ACT team members to assess the client and, if needed, provide support to maintain housing.

Providing structure is perceived to Reinforce the client's Capacity to remain housed by preventing the presence of disruptive guests who could jeopardizes a client's tenancy. Conversely, unrealistic and inflexible rules about guests could be barriers to housing retention. The "guest" rules often caused significant tension within the tripartite relationship of the client, housing staff, and the team. *Managing money* was also considered a therapeutic strategy that reinforced the client's capacity by directing monies toward rent and food and reducing the client's financial capacity for purchasing drugs. By guaranteeing rent payments, the team members met the overall goal of keeping a client in their housing.

The participants spoke of housing as reducing the harm clients would otherwise experience if homeless, and they articulated their belief that loss of housing pushed clients back into harm and away from improved capacity. However, the teams did not practice HR to its fullest extent, although true *harm reduction* is a primary strategy in promoting housing stability. Educating the client about housing rules and expectations also Reinforces the Capacity to remain housed. The onus of change, however, is on the client. The team supports the client by *reconciling the variance*, thus reinforcing his or her capacity to retain housing. Integral to supporting the client to remain housed is the relationship between the team and the housing staff.

Maintaining Relationships

Despite the use of therapeutic strategies to Reinforce Capacity, relationships among client, landlord, and housing staff can be strained. Most participants who discussed the topic of contentious interactions between clients and landlords or clients and housing staff preferred that the client defer any communication to the team instead of approaching landlords or housing staff on their own. The team also preferred the landlord or housing staff to first approach the team, not the client. Consequently, the ACT team members often *became [becoming] intermediaries* when conflicts arose, and they had to work toward *maintaining relationships*, another subcategory of Reinforcing Capacity. Hence, they become intermediaries in order to reduce conflict between the staff or landlord and the client.

The participants described how they used the strategies of maintaining, mending, or preventing further deterioration in their relationships with housing staff to prevent the loss of housing. *Maintaining relationships* is a key element in Reinforcing Capacity to remain housed. To maintain the relationship between the teams and the housing staff or landlords, the teams reported *becoming intermediaries* by deflecting tension between the client and housing staff/landlord, insulating the client, supporting the landlord by becoming a sounding board, and de-escalating tensions (or tense situations). The participants also described being sensitive to the position of the landlord and housing staff in their interactions. Team members often found themselves in the role of counsellor, diplomat, and peacekeeper in maintaining relationships and advocating for continued housing tenure.

Jayme described the work of deflecting tension, insulating the client, and supporting the landlord to de-escalate tension within the client-landlord relationship:

> The landlord might just need a sounding board. If there are moments [when] the landlord is upset with some of the [client's] behaviours, instead of going directly after the client...there's another resource that they're working with, us.

Jayme also described becoming a sounding board and deflecting the landlord’s concerns from the client to a team member who worked directly with the landlord. Alex described how the ACT team member would call or “just show up” to de-escalate the tense situation:

> [T]hose people would clash [the client with the housing staff or landlord] because they’re already charged up, angry at each other. And we’re able to come in. You know it’s almost like having a relationship counsellor assigned to your life.

Alex used the term “relationship counsellor” to refer to someone who focuses on reconciling and maintaining the relationship after the de-escalation. Another participant described herself as a “peacemaker,” and another participant perceived herself as a “diplomat.” One team member had mediated when a client was about to be evicted:

> I asserted the client’s rights to stay until the client had a place to live I went on to thank him for, you know, basically, just made a point of telling him how much we appreciated him taking a chance on this person.

The participant demonstrated sensitivity to the landlord’s position while advocating and negotiating for the client’s continued stay in the building until the team found other housing, which would take longer than the time given in the notice served by the landlord. Taking on the roles of sounding board and de-escalating tensions by being a diplomat or peacekeeper are all ways of *maintaining relationships* between the team, client, and housing staff. They are essential if the *variance is to be reconciled* and client capacity to remain housed is reinforced. Such activities preserve the possibility for the team and other stakeholders to work in *collaboration*. *Maintaining relationships* is a key subcategory in Reinforcing the Capacity of clients to remain housed.

Collaborating.

Collaborating encompasses the formal and informal *communication [communicating]* and *strategizing* that takes place within and among ACT teams, the housing staff or landlords, and/or clients to meet the goal of Reinforcing the Capacity of clients to remain housed. Effective collaboration includes ongoing communication, focusing on problem solving, and developing a plan. The conditions required for collaboration are shared efforts (team/housing staff/landlord/client), patience, the willingness to work together, getting client buy-in, gaining the client's trust, and having a strong relationship between the team and housing staff. First, I examine the conditions required and the factors for promoting collaboration in the context of the participants' experiences, and then I discuss the barriers to collaboration.

Conditions for collaborating effectively. Collaboration was identified as pivotal in helping clients remain housed. Jay outlined the reasons that collaboration between client and housing staff was important, and her insights reflected the points that other participants made:

> I know that a strong relationship between the team and housing can help with trouble-shooting, you know, when things aren't going so well with either the team or housing, to be able to meet with the client as a complete support group, you know. Because, if you're home somewhere it's… a lot of your time is spent there, if you count sleeping and eating and whatnot. So I think it…it allows the client to (a) not split teams and housing and…and (b) really see that we're all communicating with each other and, you know, we're all here to trouble-shoot this problem,

> and then we're all going to be on it together and you're going to have people at -- where you're housed checking in with you on it, you're going to have your team checking in with you on it and… so I think it…. I mean, I can't see any detriment to it, it's only ever been helpful. Having regular meetings with housing.

The *conditions* required *for collaborating effectively* are (a) ongoing communication between the ACT team, the housing staff, and the client; (b) the ability to identify and focus on a problem to develop solutions together (i.e., focusing on problem solving); and (c) having or developing strong relationships between the team and the housing staff; and (d) the willingness to work together. All ACT team participants described attending regular meetings with housing staff, focussing on clients that were described by participants as "high profile" and "the highest fliers" or addressing an issue arising with clients in their housing situation:

> We meet, for the most part, if people are having some real issues coming to the surface and whenever issues arise. For some people definitely the weekly housing meeting. It's the only thing that's keeping their housing…and new strategies come up in those meetings... So we probably have about half a dozen [high profile clients] at various sites.

Jayme described the regular meetings attended by the team at one of the housing sites:

> I mean, it might not make it down to written form as accurately as it should but there is that -- that verbal process that definitely happens.

Communication is the foundation of effective collaboration. Communication also offers the opportunity of *collaboration* at interagency meetings. One participant gave an example of successful *collaboration* in keeping a vulnerable client housed:

> From a mental health perspective he has been paranoid and violent and assaulted people. But the housing staff have helped him work on his really fragile insight. Along with us [the

> ACT team] the housing staff are engaging with him at the site and helping him process everything [understand what he needs to do]. The client is now buying in....agreeing to take more medications and he's buying into the plan. He also now asks for help to clean when needed and tells us if he is feeling physically unwell.

The participants attributed the success of keeping the client housed to the *collaboration* between the team and the housing staff, as well as to the housing staff's patience and willingness to work with the client. Their patience was crucial because the client's buy-in was not instantaneous but developed over a period of time. Without these shared efforts and the housing staff's ability to understand and work with the client, he would have been hospitalized because of his persistent paranoia, and he might have lost his housing because of his violent behaviour. The ability of both the ACT team and housing staff to collaborate in developing a plan and working toward a goal with the client made all the difference. The willingness to work together was essential in this situation.

Moreover, there were indicators that the client was beginning to trust the team by agreeing to a plan to take his medications and ask for help when he was unwell or needed help with cleaning. The participant who described this situation explained that the client also lacked insight and exhibited symptoms of serious mental health issues. In collaboration, the team, the housing staff, and the client identified the problems and focused on creating solutions. The client benefited greatly from the support of both the housing staff and the team, subsequently showing signs of stabilization, such as insight and a reduction in aggression. He also showed signs of recovery, including greater trust and self-determination.

Collaboration and communication was key in these positive outcomes and served to reinforce the client's capacity to remain housed.

To ensure collaboration, the team and housing staff or landlord needed to have ongoing communication about their concerns and the willingness to work together. They needed to include the client, thereby getting client buy-in and gaining the client's trust. The team and housing staff needed to identify and focus on the solving the problem. Finally, effective collaboration required that the team and housing staff had a strong relationship. Therefore, a number of conditions must be met for *collaboration* to occur.

Barriers to collaboration. The participants also discussed experiencing *barriers to collaboration.* These included impeded interagency communication, a hierarchical divide, jurisdiction or role conflict, and differing priorities. The participants discussed scenarios in which the team and the housing staff had divergent philosophies and different perceptions of safety, which were obstacles to collaboration.

Impeded interagency communication. In response to my questions about sharing information, such as client-support plans, with housing agency staff in the health authority's housing program and in the non-profit sector, two different perspectives emerged. Taylor stated:

> There needs to be more sharing of what the support plan is, like, more case conferencing so everyone's working on the same goals and plan for the client to be successful.

The client-support plan outlines the client's goals, how the client plans to attain them, and the type of support he or she will receive. Taylor believed that this information needed to be shared so that the housing staff and the ACT team could work with the clients to meet their goals. However, Frances was adamant “that it is the client’s information” and that “it’s up to the agency to develop their own housing support plan.”

The development and sharing of housing support plans between the team and housing staff is an area of tension. I continued the discussion on sharing client information with other participants. There was confusion about the types and extent of information that could be shared between the teams and the three types of housing sites: those funded and staffed by the health authority; health authority-affiliated sites in which the building is staffed and administered by a non-profit agency and partially funded by the health authority; and housing sites staffed and funded by a non-profit agency. There was a lack of clarity about whether sites run by or affiliated with the health authority shared computer access to client information, for example, and whether the staff at the health authority-supported housing sites and ACT teams had access to the same client-medication profiles, diagnoses, diagnostic tests, and basic demographic information.

For example, during one participant’s visit to a health authority-affiliated site which is staffed and administered by a non-profit agency, the staff member at the front desk, who has formal training in mental health and addictions, explained that she would document the ACT team’s visit on the computer. However, the participant did not know if the team communicated with the agency by e-mail, the extent to which the agency kept and updated client files, or even if there was formal communication between the team and the housing agency staff about a shared client file and/or a care plan. In discussions with outreach workers on the ACT team, I learned that in the case of health authority-affiliated sites where the building is staffed and administered by a non-profit agency, communication during formal meetings and informal discussions was rarely recorded in the client's file by the ACT teams. At the time of the study the team members thus relied on their daily team meetings to pass on information. There was no formal written communication among three of the four ACT teams and the housing sites, apart from the occasional e-mail, with the exception of one team where the team leader handled all communication with housing site staff.

Vic observed the lack of collaboration between the ACT team and the non-profit agencies, which are not affiliated with the health authority:

> I think there should be a more collaborative process with [housing] providers especially if it's health authority clients [ACT team clients] in non-health authority housing.

He also pointed out that one non-profit agency had five ACT clients but very little information from the ACT team. This participant explained that non-profit, non-health authority housing agencies receive limited information about the client, and the little information they do have comes from the referral agency, not the ACT team. Vic said there is no history of the client's previous housing, health, or substance use. In all agencies, the team and the housing agency staff have regular meetings about their most complex clients.

However, Fran believed that this was not enough:

> In all supportive housing, in my opinion, that should be a collaborative relationship and there should be regular case conferences, you know, even if it's every quarter where the team

> is sitting down with the housing staff and the client and saying, you know, "How are things going for you in housing?" Not just when there's a problem, per -- like, it tends to be when there's problematic behaviours.

The importance of *maintaining relationships* and *collaboration* has already been identified as essential to the process of Reinforcing the client's Capacity to remain housed. Fran believed that in order to promote *collaboration* and to develop a working relationship between the ACT team and housing staff, regularly scheduled case conferences needed to take place, regardless of whether there was an imminent problem. Fran clearly identified the need to involve the client in the meeting, which would encourage the ACT team's regular reassessments of how the client was progressing. Ray identified a deeper issue that was a *barrier to collaboration* by using the term, "hierarchal divide."

A perceived hierarchical divide. A *hierarchical divide* can impede collaboration and the team's ability to reinforce the client's capacity to remain housed. Ray believed that some ACT team members neither asked for nor valued the input of housing staff, and that some team members believed their "clinical role is higher" than the non-clinical role of the housing staff. Taylor explained that this divide led to a lack of consultation and communication, which precluded collaboration between the team and the housing staff. Taylor perceived that some team members considered themselves "ranked above the housing staff," in terms of both education and the team's role as clinical support to the client, and that the housing staff played a lesser or subordinate role. On the other hand, the housing staff spoke of team members coming to the housing site to drop off blister packs of medication for ACT clients residing in the building but not speaking to the staff about the clients. Two housing staff members said that they had to be assertive in getting the team members' attention, thus identifying a lack of collaboration.

The hierarchical divide and the lack of clear role definition and/or collaboration led to role conflict in dealing with several matters, such as bedbugs or the client's messy apartment. Participants described situations in which the client had broken the housing rules and the team were called to "mete out the consequences to the client" although they did not believe this was within their jurisdiction. Two participants reported that in in crisis situations, there could be confusion about whose job it was to deal with the issues that arose. Such confusion is symptomatic of the lack of clearly defined program goals in terms of clinical responsibility and housing responsibility. It also indicates the lack of both collaboration and partnership. Hierarchical divides and role conflict interfered with the team's ability to collaborate and communicate effectively in supporting the client, thus hindering their capacity to remain housed. These are also symptoms of a general lack of partnership.

Conflicting roles. Concerns about role conflict were evident when the members of one of the three ACT teams explained that they preferred to house their clients in market rental apartments with no onsite supervision because of the "duplication of roles" between the ACT team and the supported-housing staff. This duplication could be an issue at some supportive housing sites, where medication might be administered by staff, and/or life skills and vocational training are provided. This type of communal housing undermines the community integration of people with mental illness and differs from the PHF approach because it has onsite staffing and uses dedicated apartment blocks instead of scattered housing. Services such as medication administration, life skills and vocational training are also provided by the regional ACT teams.

The members of this team were also concerned about “the high frequency of meetings” with housing staff. In an attempt to reduce the number of meetings and role duplication, strong lines of communication were developed between this team and the staff at the supportive housing site. In this case, the ACT team leader handled all the communication between the team and the supportive housing staff through phone calls and e-mails, and ensured that the agency staff had the care plan generated by the ACT team for the client. The ACT outreach worker did not communicate with the housing staff during site visits to the client. Only one person, the team leader, maintained communication with the housing staff because it was believed to facilitate better communication about the client.

This team members had also built strong relationships with a number of landlords and rental agencies during their years in community mental health prior to joining the ACT team. This team’s use of market rentals was a deliberate strategy. When the clients of this team were placed in market rental housing, as opposed to staffed supportive housing sites, role duplication was avoided.

This team had worked with the same landlords for a number of years. These participants reported that even if one client had to be evicted from a rental apartment, the landlord would house another of the team’s clients. The apartments that I visited with participants on this team were well maintained, clean, in safe neighbourhoods, and close to shops and parks. The clients accepted by the landlords had primary diagnoses of severe mental illness but did not usually have a history of chronic homelessness and substance-use disorder. The other three teams did not have access to the same number of landlord-managed rental apartments in the region because the landlords were reluctant to rent to people directly from the streets. This is indicative of the barriers and social stigma that people who have a history of homelessness, substance use, and mental illness experience.

The participants on all four teams said that their relationship with housing staff was "developing" and that they were "learning to work with each other." This was confirmed by my observations: the participants had a friendly and collegial relationship with the housing staff. I also observed other ACT team members at the supportive housing sites whose interactions with staff were relaxed and friendly. These participants, although they usually visited one client, would also confer with staff about other clients residing in the building. I observed a marked degree of informal communication between the three teams and the staff at the housing sites. On the surface, the relationship seemed collegial relationship. However, two housing staff observed that ACT team members rarely spoke to them when they dropped off the blister packs of medication for their clients. Both staff said that they had to be assertive in getting the team member's attention and that members were not always open to hearing about the staff's concerns. One housing staff member said that the extent of the team's engagement with the housing staff depended on the team member; some ACT team members were more collaborative than others were. The other staff person was negative about her experience of interactions with the team. Poor inter-agency communication, role conflict, and the perception of a hierarchal divide were barriers to collaboration and reduced the capabilities of the team to reconcile the variance and reinforce the clients' capacity to remain housed.

Different priorities. Another barrier to collaboration is the differing priorities of the ACT team and the housing staff. These were the result of many variables: the context in which the two groups worked, their roles and goals, perceptions of safety and training, and perceptions of the extent to which the clients required control and structure.

The participants understood that the teams and the housing staff worked in different contexts and acknowledged the difficulties that the housing staff had in doing their jobs. One participant noted, "There is a whole team looking after one client," and "one or two [housing] staff members working with a building full of tenants, up to 25 tenants at some housing sites." Because they support one client, the team could be client-centered in their approach, whereas the housing staff members have to oversee all tenants. The participants also acknowledged that the team and housing staff have different priorities. The focus of the ACT team is on keeping the client housed and out of hospital, whereas the focus of the housing staff is to maintain order at the housing site. Although there is a desire to collaborate, the goals of the ACT teams and housing staff are very different. The participants' perception is that the housing staff's focus on maintaining peace at the housing site and minimizing disruption means that the staff are less accepting of client behaviours than ACT team members are. Consequently, different priorities are manifested in the responses of the ACT team and housing staff to clients' behaviour. The participants perceived that the need to maintain order led to the application of inflexible, homogenous rules that were not client-centred.

Further impediments to collaboration were discrepancies in perceptions of the ACT team and the housing staff regarding safety. Jeopardizing the safety of staff or other tenants is grounds for the eviction of the client. Although the participants agreed, they had differing beliefs about how situations were or should have been handled by the housing staff. The participants specifically mentioned working with clients who were perceived as aggressive. Differing perceptions of safety led to a lack of consensus on how situations should be (or should have been) managed. One participant related a situation in which a housing staff member "intervened inappropriately and was harmed," and another participant discussed how the client was responded to in a manner that "escalated the aggression." Another participant believed a situation "was exacerbated by how it was handled." The team and the housing staff had different understandings and interpretations of managing the situations that arose. The team members believed that in some instances, the housing staff lacked sufficient training and understanding to work with the client, which could lead to housing instability and or housing loss. Differing perceptions of safety were discussed by one participant who believed that a client could be "aggressive [in their manner] but not dangerous." However, the client would be deemed aggressive by the housing staff, which would lead to housing loss.

Summary of Barriers to Collaboration. Differing perceptions of safety are barriers to *collaboration* and ultimately barriers to Reinforcing Capacity. Barriers to *collaboration*, such as role conflict, hierarchical divide, and differing priorities can be obstacles to communication and collaboration, making it difficult to reinforce the client's capacity to remain housed. I perceive these issues as systemic because they are not specific to one individual or housing site. Role conflict can result from role duplication and the lack of clarity and confusion of responsibilities. This is possibly the result of combining two existing models of supportive housing with the support services of the ACT program. A hierarchal divide occurs in this situation. The service providers in each program have different sets of priorities and different levels of training in working with clients. Because they are separate programs, there is little or no formal integration. However, working in partnership and identifying shared goals could strengthen the support of clients to maintain housing.

The hierarchical divide, role conflict, and differing priorities could stem from the lack of a shared vision and philosophy to guide the provision of support to clients in the context of reducing homelessness and supporting clients to remain housed. Support provided by participating ACT teams and the housing program staff focus on managing and intervening in behaviours. When programs and systems use the word support as a pseudonym for control, and there is no shared philosophy of support to guide practice across programs, barriers will prevent clients from retaining housing, and support will be fragmented and governed by individual programs. In the case of the ACT team and the housing staff, the onus is on the client to change, not on creating a system that accommodates the client and involves the client in their decisions about housing and life. Both housing programs and the ACT team manage the clients' lives. Issues such as non-compliance with rules lead to more control by the ACT team and/or the housing staff. Thus, compliance is enforced, which further increases the risk of housing loss. Instead, organization managers could apply a systems approach to solving problems and reinforcing client capacities. Creating a forum where ACT team members can have open discussion about the issues that are arising between agencies with a focus on examining policies and practice and problem solving. When the team members, tenants, and housing staff are able to collaborate, issues can often be resolved, thus reinforcing the client's capacity to remain housed. A forum is also needed where clients/tenants can be part of discussion of rule setting and compliance.

Containing Chaos

When tenancy is at risk because a client has difficulty modifying behaviours, the participants focus on *containing chaos*, which concerns *collaborating* and being client centered. *Containing chaos* is also about working with clients whose behaviour is disruptive and does not change. The team and housing staff work to mitigate any disturbance, thus increasing the client's chances of remaining housed. The participants described containing behaviour that disturbs others and leads to loss of tenancy as "keeping everyone happy," "minimising disruption," and "reducing damage." By acting to *contain chaos*, the team reinforces the client's capacity to remain housed by reducing the chances of eviction because of disruptive or nuisance behaviour that often disturbs other tenants and violates the Residential Tenancy Act.

When the client's behaviour does not change, the team seeks to *collaborate* with staff to *contain* the ensuing *chaos*. Ideally, the shared goal is to keep the client housed. The housing staff's goal to maintain order aligns with the team's goal to help the client stay housed. In client-centered and creative approaches, the ACT team and the housing staff collaborate in developing strategies that minimize the negative effects of client behaviours that could culminate in housing loss. These strategies reduce disruption of the housing agency staff and other tenants. Thus, *reducing chaos* is an example of the alignment of goals.

Kelly described how she worked toward keeping everyone happy in a situation where a client had a chaotic sleep cycle, in which day and night were reversed. The client would walk noisily through the hallways at night, disturbing other residents by knocking on doors to talk or ask for food or cigarettes. The behaviour persisted despite complaints from tenants and the admonitions of the housing staff.

After speaking with the housing staff and the client, Kelly brought the issue to her ACT team for review at a daily afternoon meeting. The team brainstormed, identified the issues, and worked through them together. They decided to give the client her medication later in the evening to help her sleep longer into the night and to work with the client to set goals to regulate her sleep. The ACT team, the housing staff, and the client developed a plan. If the client woke and was hungry, lonely, or wanted a cigarette, she would take the shortest route to the staff room and sit there in a comfortable chair. The staff would supply her with a snack or a cigarette. The team gave the housing staff the client's "night smokes" and some cans of fruit juice and protein drinks that were kept at the front desk. The client's problematic behaviour of night activity continued. However, the collaborative efforts of the team, the housing staff, and the client were successful in minimizing the disruption of other tenants.

In another example, Frances related that a client who suffered from anxiety and depression would become anxious and paranoid when he smoked marijuana or became intoxicated. The client would call 911, resulting in the arrival of police, fire, or ambulance, which created major disruptions for everyone in the building and potential fines to the housing agency. The client was at risk of both losing his housing and being charged criminally with mischief and disturbing the peace. The housing staff worked with the client to contain his behaviour and focused on reducing the damage caused by the disruption by using a creative strategy. The client agreed to have his phone removed when he was using substances and to come to the desk for help. The staff obtained the client's permission to monitor him when he was intoxicated. This prevented further 911 calls and reduced the risk of eviction.

In each case, it is important to note that the client's behaviour did not change. The first client continued to walk the hallways at night, and the second client persisted with substance use, but not in calling 911. Their vulnerability to tenancy loss was mitigated by reducing the negative effects of the behaviour. This is an example of the application of the HR approach. The approach taken with both clients was both client-centered and creative. The housing staff were engaged with the team, and all focused on the problem-solving process. The housing staff demonstrated tolerance and creativity in working through the behavioural issues. Finally, the housing staff were flexible concerning the housing rules and did not move immediately to evict the clients because of their behaviour. The team members reinforced the clients' capacities to remain housed through their therapeutic interactions with them and by maintaining a collaborative relationship with housing staff that facilitated problem solving.

By *containing chaos*, the participants Reinforced the client's Capacity to remain housed. This was achieved by containing behaviour that disturbs others and determining how the situation could be managed in order to keep everyone happy. In most cases, this is done by minimizing disruption to others or reducing the potential damage. In the process of containing chaos, the team and the housing staff work together toward a shared goal.

Juggling the Variance

The participants also provided multiple examples of negotiating with the client and the housing staff to keep the client housed when **he or she** was at imminent risk of losing housing. I call this sub-category *juggling the variance*. *Juggling the variance* includes the following strategies: *bargaining and buying time*, and *advocating*. *Juggling the variance* includes the participants' negotiations with the client and the housing staff to keep the client housed. In these scenarios, the team considers what the "client would go for," and "what the housing staff will put up with." There is a variance in the conditions the client has to meet to remain housed, the team's perception of the client's capability to meet these conditions, and the client's willingness to live within the set parameters. In *juggling the variance*, the client can be directly involved in the decision-making process. In other words, the team considers the parameters that the client is prepared to accept and the latitude or scope that the housing staff are prepared to give the client. The team uses two strategies: *bargaining and buying time* and *advocating*.

Bargaining and buying time. One of Lee's clients had been housed for three months. Halfway through the fourth month, the client was banned from having guests because he was having loud parties. The housing agency staff also told the client that his lease would not be renewed at the end of the month. When Lee spoke to the housing staff, they expressed that they were no longer prepared to put up with the disruption. The client felt that he was being unfairly treated. He wanted to remain housed, but he did not want to concede to not having guests. The team asked the housing staff if they were prepared to review the client's tenancy status if he did not have guests for the two weeks until the lease renewal date. Despite the housing staff's reluctance to renew the client's lease and the client's dissatisfaction, a compromise was reached. If the client did not have guests for two weeks, the lease would be renewed. Thereafter, the client could have a guest in the daytime. In this case, the team was successful in continuing the client's tenancy by bargaining with the housing staff and buying time. In another situation, the team members bargained for and bought time for a client; consequently, the client's tenancy was renewed for one more month on the understanding that the team would look for other accommodation with a less restrictive policy. Because less restrictive housing is difficult to find, the additional time was important in keeping the client housed.

The team may also have to bargain with clients to provide interim housing options. For example, one of the teams has access to a respite facility, as the participant said to give the "housing staff and other tenants a break" or to accommodate a client if the client’s apartment must be professionally cleaned. The participants on this team believed that having access to the respite bed helped their clients to remain housed. In one case, the team had to negotiate with the client to get them to agree to be admitted to the respite facility. The team also had to work with the housing agency to obtain an agreement to keep the client’s housing available until the difficulty was resolved. Retaining the client’s housing in this way further reinforced the client’s capacity to remain housed and even promoted housing stability. At the time of this study, the other teams did not have access to this respite option. Placing a client in respite has the potential to buy time to clean the apartment, negotiate the client’s on-going tenancy, or allow a tense situation in the client’s housing to settle. This seems an effective strategy in supporting the client to remain housed.

Advocating. Another strategy used by participants to juggle the variance is *advocacy*. In some situations, the teams advocated for clients to remain housed on the basis of “the client’s strengths” and what “they are working on.” For example, one client’s tenancy was at risk because of her behaviour when she used substances. She had made the choice to accept treatment for her substance use and was wait-listed for a placement in a treatment facility; this choice was supported as part of the spectrum of harm reduction measures. In *advocating* for the client, the team negotiated ongoing tenancy with the housing staff by emphasizing the client’s goals and strengths: “This is the behaviour that you’re seeing, this is the progress the client has made, [and] this is what the client is working on. Here is the plan now.” The participants believed that demonstrating client progress is an effective strategy when negotiating with housing staff to continue a tenancy. Thus, *juggling the variance* requires the ability to *bargain*, to *buy time*, and to *advocate* for the client to remain housed.

Summary of Reinforcing Capacity

Reinforcing Capacity is the core category in the teams' social process of supporting the client to maintain housing. The teams seek to resolve the problem of reconciling the variance between capabilities and characteristics, which influences the client's capacity to remain housed and the conditions and expectations that the client has to meet to remain housed. In this section, I discussed how the teams work with their clients by employing of a wide range of therapeutic strategies that include managing medication to stabilize the clients mental health and behaviour, and providing structure to promote compliance with housing rules and therefore housing retention. Conversely, using structure as a form of client control can be not only a barrier to not only housing retention but also *maintaining* the therapeutic *relationship*.

By managing money on behalf of the client, the team ensures that the client's rent is paid, thus reducing his or her financial capability to purchase substances. This is perceived as supporting the client to remain housed and reducing harm to the client. However, because the focus of regional ACT programs is on recovery and does not fully subscribe to the HR program, these measures alone do not constitute HR.

Educating the client concerns the housing rules and social interactions that can support him or her to remain housed. As in all circumstances associated with therapeutic interactions, education concerns moving the client toward meeting the expectations and conditions of being housed and complying with societal norms. However, the dichotomy is that in theory, housing programs do not expect the client to be housing ready in order to obtain tenancy; yet, the client is expected to able to conform and fit within the existing housing situation. The ACT team members often became intermediaries when conflicts arise within the housing staff or landlord client relationship, and they work at *maintaining relationships* by deflecting tension between the client and housing staff/landlord and becoming a sounding board for all parties, often by de-escalating tension or tense situations. The teams consider that *maintaining relationships* with the housing staff and *collaboration* are key to keeping their clients housed. The participants identified the conditions of successful *collaboration*: ongoing communication, a willingness to work together, the ability to focus on problem solving, and commitment to developing a plan. A strong relationship between the team and the housing staff or landlord works toward Reinforcing the client's Capacity to remain housed. However, there are barriers to collaboration, including role conflict, a hierarchical divide, and differing priorities and perceptions of safety.

When the client's behaviour does not change, in order to keep the client housed, the participants seek to mitigate the disruption that the behaviour causes, thus *reducing chaos*, which narrows the variance by both accommodating the client's behaviour and Reinforcing the client's Capacity to remain housed. This is accomplished by minimizing disruption and reducing damage. In *juggling the variance*, the participants spent time negotiating with the client about their compliance with parameters and conditions of housing and with the housing staff regarding the scope of these limits. Successful negotiation Reinforced the client's Capacity to remain housed. The strategies used include *bargaining* for ongoing tenancy with both the housing staff/landlord and the client and *buying time*. *Advocating* for the client also helped to secure their ongoing housing tenure and Reinforce the client's Capacity to remain housed.

The participants also valued being client-centered, creative, tolerant, and flexible in reaching a satisfactory solution. However, during the study, it became apparent that in some cases, significant barriers hindered both communication and collaboration. As identified by both housing staff and team members, these were inherent in the differing roles, perspectives, and training of the ACT team and housing staff, as well as the complexity of the clients.

The participants worked to support the client to remain housed by *juggling the variance* between the clients' characteristics and capabilities and the conditions the client has to meet to remain housed. Reinforcing Capacity is the central process in *juggling the variance*. The participants, when they could, negotiated flexibility and leniency in the application of housing rules and conditions that the client had to meet, thus moving the client toward the rules and moving the housing agency and landlord toward an understanding of the client. In doing so, the participants emphasized client-centeredness. Team members worked with the client toward self-actualization and independence; they frequently struggled between upholding the client's autonomy and providing the structure to support the client to remain housed. The support plan sometimes became housing site-centric instead of client-centered.

This work to support the client in maintaining housing represents the inner structure of how the ACT teams provide community support to this population.

In the next section, the major category of Enforcing Conditions describes how structures of societal living are imposed on clients and the direct consequences of non-compliance with those conditions. Enforcing Conditions is the coercive side of Reinforcing Capacity and compels the client to meet conditions and imposes the consequences of failure. Please see table four below for the categories and subcategories of this major category.

Table 4: Enforcing Conditions

Major Category	Subcategories	Types Circumstances/Conditions
Enforcing Conditions	*Regulating*	*Developing Behavioral Contracts* *(also referred to as team approach/ putting the client on a program)* Working with client to understand the consequences Encouraging the client to think through the consequences, Reviewing choices and options *Calling in the police officer* Enforcing compliance/adherence Referring to an external authority *Monitoring the client* Locating the client Assertively engaging DE terming infractions (breaking curfew) Regulating compliance *Warning the client*
	Compelling	*Enforcing legislation* Enforcing the Mental Health Act Enforcing conditions set by ICS (curfews, substance use rx, who client can associate with/red zones) *Going back in front of judge*
	Collaborating	*Providing realistic plans* Judge participant & client set conditions Explaining collaboration to the client Consequence Directing behavior in the community, Having more teeth/power Blurring the line Feeling supported in their work (team) Eroding the therapeutic relationship

Enforcing Conditions

The category Enforcing Conditions concerns how the client is compelled to live within the structures set by the rules and conditions of the Tenancy Act, the Mental Health Act, societal norms, and the law. The client's non-compliance with any condition, such as mental health treatment, non-adherence to the behavioural contract with the team, the client, and housing staff, the conditions set by the ICS, or breaking the conditions of tenancy, has direct consequences. The ICS provides an alternative to jail for those who break the law and commit crimes related to their mental illness and/or addiction. These people are often repeat offenders with histories of the multiple use of emergency and police services. The court describes its purpose as "providing a helping hand" to clients who are "supported by a team of professionals," which in this case are ACT teams. By choosing this alternative to jail, the client must agree to participate in the ICS and work with the ACT team.

These conditions provide structure for the client's placement in the community. These include place of residence, mandatory treatment for substance use, and working with the ACT team. The conditions impose curfews and prohibit associations with certain individuals and frequenting certain areas of the town or city. The ICS judge knows that the team has become familiar with the client and is thus aware of what has and has not worked for the client in Reinforcing Capacity. Therefore, in Enforcing Conditions, the ICS judge requests the team to make suggestions and contribute to setting conditions. The judge may accept or reject their suggestions. Hence, the ACT team is party to ensuring that the client meets the conditions set by the ICS. The team members perceive that Enforcing Compliance helps reinforce the client's capacity to remain housed.

Enforcing these conditions takes place through the sub-categories of *regulating, compelling,* and *collaborating*. *Regulating* refers to actions that control the client's behaviour and includes warning the client and making appeals to authority. *Compelling* uses the force of the law to ensure compliance, whether through the Mental Health Act or the ICS judge. *Collaborating* describes how the team works with the ICS judge. The actions of *regulating*, *compelling*, and *collaborating* are the processes by which conditions for community living are enforced.

Regulating

This is the first step in Enforcing Conditions. It begins with encouraging the client to think through the consequences and includes the strategies of *developing behavioural contracts*, *calling in the police officer*, *monitoring the client*, and *warning the client*. Any or all of these strategies regulate the client's behaviour, reminding them of the conditions they need to meet to remain housed.

Two participants identified the need to work with clients to help them understand the consequences of not following the rules of tenancy. One participant described reviewing with their clients the choices available in order to help them think through the consequences. These consequences could include loss of tenancy, that is, homelessness, and, as a result, infringement of the ICS conditions and/or appealing to the power of the ICS, the police, or the probation officer.

Enforcing the Conditions of tenancy was described by one participant as a team approach or *developing a behavioural contract*. That participant's team develops a written protocol for the housing staff to manage a client's specific behaviours:

> So they'll have a service plan and then they'll have separate team approaches as well for, you know, behaviours that really need everybody to be aware on how exactly they are to be handled, that's been effective in the past. So they're [the team approaches] always growing and changing and -- you know, so we'll go back to meetings, 'cause they still happen, and it'll be -- not a lot of the time, sometimes.

Another participant in this team explained, "The team approaches are for behaviours that really need to be extinguished, right? So [the housing staff will] read that off." The team approach provides a script that the housing staff can use when speaking to the client about unacceptable behaviours. The client is aware of the team approach and knows what to expect if certain behaviours are exhibited. The team approach also directs the housing staff in how to respond and clients regarding how they should behave. In this team approach, the housing staff also calls the police or the ACT team, depending on the behaviour. The participants from the one team that uses this approach believed it was practical for clients who "respond well to structure," such as those who have a severe mental illness.

Sometimes ACT teams resort to *calling in a police officer* to encourage the client to comply with the conditions of community living. Police officers are assigned to three of the ACT teams, and in one case, the officer is an integral part of the team, thus becoming acquainted with both the team members and their clients. In providing authority beyond the team, the officer plays an important role by ensuring that the client complies with the conditions imposed by the ICS. Although the police officers might not charge clients for breaching ICS conditions, they encourage the client to adhere to them. Jayme stated:

> The police officer works with the team and assist us in monitoring the client.... if someone isn't, you know, following the conditions - for example we know JR is going out after his curfew, you know, the police have never found him, which is -- there's been no formal breach, but we know he's leaving after his curfew. The team could ask the police officer [attached to our team] to come with us to talk to him about that, to just let [the client] know that, you know, that he could be breached by the police. I mean, you know, just having that conversation.

The police officer is called upon to help remind clients of the conditions they have to meet for community living and support the team in *monitoring the client* and *warning the client*. All three teams can ask the officer to look for clients that they have been unable to locate, which ensures that they continue to engage assertively with the client. The involvement of the police officer also serves as a pre-emptive warning to the client. The officer can accompany the team to the client's accommodation if the team believes the client is not complying with the tenancy rules or engaging in unlawful activity that could lead to housing loss. Involving the police officer reminds the client both of the conditions they must meet and the consequences of non-compliance, which can be a significant factor in the client's maintaining housing.

Regulating with a view to modifying the client's behaviour is perceived as supporting the client in meeting the conditions of community living. The police officer works with the team in this first step of Enforcing Conditions by *monitoring* and *warning* clients and regulating their compliance. Further steps can be taken if the client continues in non-compliance with the conditions.

Compelling

The second subcategory, *compelling*, includes the strategies of *enforcing legislation* and *going in front of the judge*. Enforcing legislation, specifically the Mental Health Act, and going in front of the judge with the client, that is, working with the ICS to enforce the imposed conditions, compel clients to comply.

Enforcing legislation. A severely mentally ill client's non-compliance with treatment has direct consequences. One participant described a client who refused to take her long-acting antipsychotic medication:

> So there is a client who doesn't want an injection, she makes that very clear, and basically the police officer comes with us. So if she refuses, there's already a warrant and we can bring her straight to the hospital, so it just saves that time.

The police officer assigned to one of the three ACT teams, as discussed above, often becomes involved when the client needs to be apprehended ("sectioned") under the Mental Health Act.

> We have a police officer attached to our team and the same officer does a lot of our Mental Health apprehensions so, when someone does refuse their medication, or when someone is quite ill and they are on extended leave from the hospital and the psychiatrist puts out a Mental Health warrant, a police officer is available who does the apprehension for the teams.

Going in front of the judge. Approximately one-third of the clients of all four ACT teams are involved with the ICS. To participate in the ICS program, the client has to plead guilty, agree to live by the court-imposed bail conditions, consent to work with the team, and work to address their underlying issues of mental health and addictions. If the client does not comply with these conditions, the team attends the ICS court with the client and discusses the concerns with the judge. One participant explained how the conditions imposed by the ICS relate to housing their ACT clients and how the client might be compelled to stay housed:

> You know, "reside where directed by your probation officer or your A CT Team member. Reside where directed." So if the team is saying, "We found you housing at this residence," and the person says, "No, I don't want to live there, I want to go live with my boyfriend," who the team thinks is a bad influence, uses drugs, deals drugs, whatever, they can say to the person, "No, you need to stay in the housing we've given you" and, if you don't -- if you're not okay with that, then we need to go back to court and talk about it in front of the judge".

The client is accountable to the criminal justice system. If a client is jailed or awaiting sentencing, and the period extends over 30 days, they are no longer eligible for rent subsidies through the ministries, and can therefore lose their housing. Compelling a client to live within the conditions imposed by the courts, as reported by the participants, keeps him or her both housed and out of jail. Thus Reinforcing Capacity is met by Enforcing Conditions.

Like regulating, compelling involves moving the client toward becoming a productive member of society and reducing the costs to society incurred by the client's use of emergency services and the criminal justice system. The alternative for these clients is jail. The ICS system recognises that jail is not appropriate for people who commit crimes because they live with mental illness and/or substance misuse. These crimes, as discussed in ICS court report, are frequently related to poverty, substance use, or mental illness. In *compelling* and *regulating*, reconciliations of the variance are imposed through actions that are taken to enforce court-imposed conditions. In regulating and compelling, the ACT teams work with the ICS judge and the police officer to Enforce Conditions for community living. These parties work together for the client by *collaborating*.

Collaborating

The strategies that make up the spectrum of *collaborating* include *providing realistic plans.* In collaborating with the ICS process, the team members work with the judge to provide realistic plans for community support by directing the client's behaviour in the community. The teams are supported by the ICS in implementing these plans. By *collaborating* with the judge, the teams are in the position of having more teeth in supporting their clients to meet the conditions of community living, including those related to housing. When the client and the team go back in front of the judge, the team is also supported. A few participants, however, expressed concerned that in their relationship with the ICS, they are blurring the lines in their therapeutic relationship and practice.

Providing realistic plans. By collaborating with the ICS judge, the ACT teams and the court can *provide realistic plans* to govern the client's behaviour in the community. The Integrated Court System Report (2010), which summarizes the ICS court process in its first year of operation, provided useful data for this study about how groups collaborate in Enforcing Conditions to support clients in maintaining their housing. These data included and corroborated statements by ACT team members, the ICS judge, and police and probation officers, and their remarks concerning the teams' contributions. The teams provide the court with realistic plans, and the intensive supervision and the support necessary to make the plans a reality, thereby increasing the likelihood of rehabilitation. The client knows that the court has the ability to impose punitive sanctions for any breach of the court orders, thus enabling the teams to direct the offenders/clients behaviour in the community.

The ACT teams have the option of appealing to the authority of the court if the client does not follow court orders. The argument put forward by the judge in support of this collaborative partnership is that the prospective rehabilitation of the client is based on the following: (i) the development of a realistic care plan, (ii) increased punitive support, and, as discussed by participants, (iii) regular, sometimes weekly, reviews of and adjustments to the plan. Although the report specified "punitive sanctions," the participants in this study used the term *having more teeth*.

The participants believed that working closely with the judge in the ICS allowed the teams to be more effective in supporting the client to remain housed. Vic explained:

> I think mostly the way that one would work would just be that, once someone is involved in the criminal justice system and they go through integrated court, then there'll be those -- there'll be those conditions to reside where directed, to work with your team, those kind of conditions, that just give the team a little more teeth in terms of supporting that client.

Vic's statement reflects the opinion of other participants that the collaborative partnership between the ACT team and the ICS Judge gives the team more teeth or power because by appealing to the authority of the judge, the client is more apt to comply with conditions such as the place of residence. Sandy also thought that making the client accountable to the judge supported the teams in working more effectively with the client. Generally, client reviews are initiated by team members in collaboration with the ICS:

> … the money management part—it just gives them a little bit more teeth in terms of dealing with that client so, when that client isn't cleaning their room or their tenancy is in jeopardy because of unwanted guests, they can be brought back in front of the judge and, you know, explain to the judge why they're not following the rules of the residence.

Sandy was specific about how the ACT teams' collaboration with the ICS in setting and Enforcing Conditions can reinforce the client's capacity to remain housed by ensuring that the client follows the rules regarding housing. Other participants believed that this collaborative partnership complements and supports the work of the team. The participants also said that the client and team meet with the judge not only with respect to misdemeanours but also for the judge to hear positive feedback, which can result in the lifting of conditions. Although most participants said that collaboration with the ICS supported their work, three voiced concerns.

Two of these participants were concerned that their *collaboration* with the ICS could negatively affect the therapeutic relationship with the client. Another participant used the term, blurring the lines. Conflicts in two areas were described: trust and practice. Although working with the client within the ICS supports the goal of keeping the client housed, it can also place a strain on the team–client relationship. The participants stated that they based their practice on the principles of MI and HR, both of which support self-efficacy and avoid coercion in a program. However, the ICS is inherently coercive. Nevertheless, the ACT team members must comply with this program in working with the client. Therefore, the philosophy of the ICS program determines their practice. Even if individual participants believe they should practice the principles of HR, their practice is determined by court-sanctioned treatment and the condition of abstinence placed on the client.

The team members need to convince clients that their involvement with ICS is indeed in their best interests, while continuing to ensure that they believe that the team is there to support them. According to one participant, a client became upset when the client's behaviour was discussed with the judge. The participant had to explain his actions to the client afterward:

> So sometimes we'll leave the appointments and the client will say, "You shouldn't have said that," and I say "Remember, that wasn't about you, it's about the behaviour—you're not going to jail."

In building the therapeutic relationship, the participants work to help clients believe that the team is on their side. When a member of the team speaks with the judge about a client's misdemeanours involving behaviour and substance use, the team member is both collaborating and directly involved in enforcing conditions, which results, according to one participant, in a conflict of practice. Chris spoke of "walking the fine line" in the ACT team–ICS relationship, which involved "blur[ring] the lines" between empowering the client to care for their health and making autonomous decisions versus telling the client to take action:

> …you have to be very astute when working with a client in promoting their health and in disease prevention … when you are trying to bring someone into discussion about their own health and what that looks like versus "now you need to follow what I am saying to be healthy."

Blurring the lines between the client's autonomous decision-making and responding to instructions is foregrounded when the ICS mandates that the client must have a plan for addiction treatment and be accountable for it. Some participants worried that these blurred lines could lead to a regression in the therapeutic relationship between the team and the client. The teams are supported by the ICS in implementing client support plans.

By *collaborating* with the judge and appealing to the authority of the judge, the team has "more teeth" in supporting clients to meet the conditions of community living within their housing situation. Collaboration with the judge in developing a support plan allows the team to bring forward what they have learned in Reinforcing Capacity and Learning How. This brings both the client and team further toward reconciling the variance between the client's characteristics and capacities and the conditions of remaining housed. The ability to move toward *reconciling the variance* is promoted when the team and the client go back in front of the judge, keeping weekly appointments, and revising the support plan.

There is, however, direct conflict with the client-centred philosophy to which the teams aspire, which is non-confrontational, non-coercive, and client-driven, reflecting the principles of MI (Miller & Rollnick, 2002) and the non-authoritarian premise of HR (Tararsky & Marlatt, 2010). The teams work under the constraints of ICS, which means the client is compelled to comply with conditions. Although this practice is significantly non-client centred, it is deemed in the client's best interests.

Summary of Enforcing Conditions

Enforcing Conditions compels the client to live within the structure set by the rules and conditions of the Tenancy Act, the Mental Health Act, societal norms, and the law. *Regulating,* the first step, starts with the client's awareness of the consequences of non-compliance, which could result in homelessness or jail. One team makes a behavioural contract with the housing staff to counter unwanted behaviours that could threaten tenancy. The teams can appeal to authority by calling in the police officer who warns the client. The team members and the police officer may monitor the client by regulating or supervising their behaviour and applying pressure to ensure the client's compliance. When conditions are enforced, the client's capacity to remain housed is reinforced.

Compelling i*s* the second strategy used in Enforcing Conditions. The team members enforce legislation by using the Mental Health Act to obtain compliance with treatment and *going in front of the* (ICS) *judge* with the client to discuss behaviours with respect to the client's housing situation, substance use, or complications with the conditions for community living. Compliance is assured by the presence of an authority that enforces the consequences of non-compliance.

In *collaborating*, the team members perceive that the partnership with the ICS results in having more teeth or power, by appealing to the judge's authority to compel the client to comply with conditions, such as their place of residence, thus ensuring the client's ongoing housing tenure. On one hand, some participants believe the process of Enforcing Conditions supports and advances their work in Reinforcing the Capacity to remain housed.

On the other hand, some participants experience conflicts in their client-centered practice, which potentially erodes Developing a Therapeutic Relationship. Attempts are made to reconcile this variance by compelling the client to meet conditions and applying consequences for failure to do so. Through *regulating* and *compelling*, Enforcing Conditions is directly linked to the core category of Reinforcing Capacity. Even so, despite the collaboration in Enforcing Conditions and the actions taken in Reinforcing Capacity, some clients lose their housing.

Table 5: Negotiating Re-entry to Housing

Major Category	*Subcategories*	*Types Circumstances/Conditions/*
	Struggling with the variance	*Being unable to intervene* Circumstances Sudden eviction with no discussion Client decompensates or relapses Lifestyle of client –brings “traffic” “johns” into the building. Illegal activities Consequences Client is pushed out of housing back into harm Difficulty to rehousing the client *Lacking a contingency plan* Circumstances For relapse in mental illness For relapse in substance use For overall eviction prevention *Perceiving there is a black book* Circumstances Client is banned from everywhere Being screened out of housing placements Labeling *Wishing* For more flexibility in rule application For client centeredness To work with those making the rules To have more say in the housing placement process For culturally safe practice (participant x1) *Hoping and Praying* For a housing placement-someone will take the client Circumstances Banned form most places Market rent only-slumlord residences *Sheltering: The client can be placed in a shelter only* Poly-substance use Refractory client Undiagnosed mental illness To protect the safety of others.

Table 5: Negotiating Re-entry to Housing		
	Narrowing the variance	*Guaranteeing intensive support* Advocating Guaranteeing rent It could be different this time Building on demonstrating clients past success and progress *Becoming housing site-centric* Not going at the clients place Establishing client compliance With housing rules *Negotiating and overcoming marginalizing factors.* Roll modeling behaviour (x 1 team) "Selling the client"/promoting the client

Negotiating Re-entry to Housing

Situations arise where the client is suddenly evicted and the team must re-negotiate the client's re-entry to housing. The participants discovered that some clients became known to housing agencies and landlords because of their breaches of the Residential Tenancy Act, and thus were "banned from everywhere," making their re-entry into housing difficult. Many circumstances could lead to eviction. Participants discussed many of the circumstances that led to clients being evicted from their housing, which demonstrates the struggle that the teams have in reconciling the variance.

In Negotiating Re-entry*,* the ACT teams are struggling with the variance. They work toward narrowing the variance to convince the housing agency and housing staff that the situation will be different this time. When the participants discussed the circumstances leading to their experience of struggling with the variance in the negotiating re-entry system, they emphasized the program barriers to housing retention and access. The circumstances that lead to the participants' struggling with the variance require the participants to negotiate re-entry to housing. Clients are evicted from housing for several reasons, such as the landlord's frustration because the client's lifestyle is incongruent with tenancy (e.g., engaging in illegal activities and bringing "traffic" into the building) or concerns for the safety of the housing staff, landlord, or other tenants because of the client's behaviour.

Struggling with the variance

In *struggling with the variance*, the teams recounted their experience of *being unable to intervene*. It became apparent that in housing loss related to relapse, the teams lacked a contingency plan. Barriers to negotiating re-entry led some participants to perceive that some clients were black-listed. I will now discuss the sub-process of each subcategory in *struggling with the variance*.

Being unable to intervene. The participants suggested that behaviour leading to evictions is often sequential to decompensation in mental illness or relapse in substance use. In relapse situations, the common factor is that the client behaviour is framed as a safety concern. The participants thought that safety concerns were sometimes misplaced when housing staff evicted a client. Ray described one incident that followed an angry confrontation between a client and a landlord. The frustrated landlord handed the client his month's rent money and told the client to leave:

> This person [the client] was extremely challenging right from the get-go, the landlord just threw the cash, you know, or the rent, "Here you go," like, "get out of my . . . building. Here's your money, your rent money. Now go away." That's literally how it happened -- the money didn't get sent back to the Ministry, it was just "Goodbye. We know you have an addiction, this is going to get you out of our building really quickly. Here's your cash. Go spend it on your drug. Goodbye. Lock the door. Put your stuff out."

In this case, there was no discussion between the landlord and the team. Hence, there was no opportunity for negotiation to resolve the issues that had led to the loss of tenancy or for any intervention to reduce harm regarding the client's substance use or housing loss. The team heard about the incident well after the event and were unable to intervene; the client, now homeless, spent this large amount of money (i.e., the refunded rent) on drugs.

Clients who use substances or whose lifestyle does not otherwise conform to societal norms are highly vulnerable to stigma and housing loss. As discussed earlier in this chapter, the housing staff may restrict a tenant's visitors if the tenant has a history of “guest issues.” This could mean “traffic,” that is, guests who use or sell drugs or “johns” (i.e., customers of sex-trade workers):

> And I think there are people who, after living on the street for a long time, will always have a lot of difficulty finding -- maintaining housing because they don’t want to follow anyone’s rules so they are going to have -- they’re going to work out of -- you know, if they’re -- females, street workers.... they’re going to work out of their room, they’re going to have guests over, they’re going to use drugs.

At most supportive housing sites and landlord-run buildings, engaging in illegal activity such as sex work puts the client’s tenancy at risk and can lead to (sometimes immediate) eviction. At one low-barrier housing site in the region, most housing staff will not intervene unless the customers of the sex-trade worker or the worker cause a disturbance that interferes with the safety of other tenants or their ability to enjoy their own premises. Few other housing options exist for clients who engage in such activity. The participants stated that “housing is harm reduction” and that being housed provides a safer environment, in contrast to meeting johns in their cars or being taken to an isolated spot. All these situations place the worker at greater risk of being assaulted. The participants argued that clients who lose their housing because of sex work are being “pushed back into harm,” and their physical safety and health are compromised. The participants located sex trade work in the context of poverty, substance use disorder, and the client’s life history. With respect to housing their clients, the participants reported encountering socio-legal barriers to the client’s remaining housed (Kruis et al., 2012) and to Negotiating their Re-entry to housing.

The participants also reported that sudden eviction during relapse of mental illness or recovery from substance use also results in the client “being pushed back into harm." Jayme described a client that had been clean for a year and was living independently in a rental apartment. The client relapsed and while intoxicated began to shout and became verbally aggressive toward a person carrying out repairs in the building. The client was evicted. Other participants related similar incidents in which clients who had relapsed became verbally aggressive, in some cases toward the landlord or housing staff and in others toward other tenants. Despite their long periods of sobriety, the clients in these cases were evicted.

Clearly, clients can be evicted because of their behaviour during relapse. Even if it is known, the context of the client's behaviour is rarely considered. Although relapse is part of the journey of recovery from substance use, and mental illness is a chronic disease in which a client can experience relapse or decompensation, behaviour related to relapse can lead to eviction from housing. However, although the participants saw themselves as traveling with the client through their mental illness and the ups and downs of addiction, the teams did not routinely provide contingency plans for relapse management. Nevertheless, the fact that contingency plans are not developed to deal with relapse means that participants do not accompany their clients on the full journey of recovery.

Lacking a contingency plan. Dana described a client with a mental illness who was housed at a supportive housing site and had stopped taking her medication for a few days. She relapsed and exhibited symptoms of psychosis that included aggression. The housing staff called the police. She was hospitalized and subsequently evicted. Participants agreed that safety of the housing staff, the client, and other tenants was the paramount concern. However, they also reported that at times, housing staff and landlords continue to interact with a client who is de-compensating (i.e., showing signs of instability in their mental illness) instead of contacting the team immediately, thus potentially escalating the situation or putting themselves at risk. It is important to note that the staff at supported housing sites have diverse levels of training and experience. Some are very experienced and trained in the area of mental health and addictions, whereas other personnel have very little or no formal training. Lack of training manifests in how the staff member responds to issues that arise in working with the client who is problematic or aggressive. An experienced housing staff member said that the lack of appropriate training means that a staff member often becomes rule- and policy-bound, lacking flexibility and initiative when dealing with problems. The client is then more likely to be evicted.

In this and similar examples, a number of program and system issues were identified. Although the system was established to break the cycle of homelessness, clients can lose their housing as a sequel to the relapse of mental illness. Significant shortfalls are the lack of an agreed standard of training for all housing staff and the lack of a contingency plan for relapse that is understood by all parties. The team members also remarked that many instances of decompensatory behaviour could have been managed by staff and the team without resorting to the extreme measure of eviction.

Experiencing a disciplinary divide. Housing-site staff have a zero-tolerance policy for aggression; any aggressive behaviour might lead to immediate eviction. The participants described that at times their perceptions of safety differed from those of the staff at supportive housing sites. The team members believed that staff concerns for safety can sometimes be misplaced. Lee reported a situation in which a tenant (who was an ACT client) and her partner (not an ACT client) were arguing outside her residence and then began to hit each other. A staff member called the team to report the incident and to advise them that the female client was being evicted because of the agency's zero-tolerance policy for aggression.

Lee believed that because the situation occurred outside the building, it posed very little risk to the housing staff and other tenants and that it was regrettable that housing staff had not been more "flexible," instead of opting for a rules-based approach by immediately applying the non-aggression policy. In a flexible approach, the housing staff could have waited for the couple to calm down and then worked through the issues with the client and the team. Alternatively, the staff could have called the police if the client's behaviour was perceived as a threat to either party or the staff. In Lee's view, the physical and verbal aggression expressed during this domestic dispute, which was typical of this couple, happened outside the building and was not threatening others. This is a clear instance of how the teams' tolerance for and perceptions of aggression differed from those of the housing staff.

Lee was understanding the variance by looking at the client's behaviour within the client's context and using her skills to "work through the issues" with the client. She believed that the behaviour did not warrant eviction and that the loss of housing pushed the client back into harm.

Dana suggested that some clients could present as "aggressive but not dangerous," that is, aggressive in their manner and speech without escalating behaviour. Other participants described clients who were rough in manner, and for whom verbal aggression was typical in their interactions. However, currently, no process is in place to address these different perspectives as they relate to supporting the client to remain housed, which further contributes to struggling with the variance.

My analysis of the scenarios described above, in which clients were suddenly evicted from their housing, showed collaboration between the ACT team and the housing staff or landlord. When the team was unable to intervene, I observed that both lacked a contingency plan and experienced a disciplinary divide. I identified that a strong working relationship between the team and the housing staff and between the team and landlords was essential in Reinforcing the client's Capacity to remain housed. These scenarios indicated a real need to strengthen and maintain the working relationship (i.e., between the team, the client's housing agency, and/or landlord), not only at the level of practice but also at the organizational level, where efforts could be made to strengthen interagency partnerships and communication.

Perceiving that there is a black book. Participants reported that some clients became known to the supportive housing agencies and landlords because of their continued breaches of the Residential Tenancy Act (e.g., aggressive behaviour and illegal activity), so they were excluded from some housing sites. All agencies that provide supportive housing in the region are represented on the central housing selection committee, which places referred applicants in housing. The participants spoke of clients who had been housed with several housing providers but now "were banned from everywhere," had "burnt all their bridges," or "exhausted their [housing] resources." One participant commented that when her client's name was mentioned to the housing agency, staff responded with an emphatic, "No! No! No! We won't take them." The participants said that clients should not be "banned" or "black-balled forever" by a housing agency and that many clients needed time to transition. Many clients had to try to make the transition several times before they could remain housed. Some participants joked about the existence of a "black book" of clients banned by both landlords and housing agencies. The team members explained that while there really was no such book, it felt like one existed because "everyone" talked to each other about potentially disruptive tenants.

Ray voiced the concern that the centralized regional process for placing people in housing might "not serve to place the client appropriately" but "screen the clients out of the process," specifically clients with a history of problematic substance use. Alex also perceived that providing the required information about the client's substance use and housing history, including previous evictions, reduced the client's likelihood of being housed. Instead of narrowing the variance by identifying the client's housing needs and using the process to house them appropriately, the process might serve to widen the variance because housing issues screened some clients out of the process.

Although clients do not have to accept treatment in order to be housed, it seems that having a substance use disorder is a barrier to being housed. Although the regional program seeks to house clients with such history, there is no clear plan to work with those clients beyond increasing control and restricting behaviour, which does not work with many clients, particularly those who the teams described as being less directable. The teams' options for housing some clients with substance use issues are reduced to landlord-run apartment buildings or shelters. The participants reported the difficulty of finding affordable rental apartments and landlords who are prepared to accept ACT clients. Dana described this problem as follows:

> Landlords and housing agency staff understand that we can stabilize mentally ill clients with medications and give medications PRN [when they are needed] and we can provide structure and all that. However clients who use substances [problematic substance use] are less predictable and do not necessarily respond well to structure. There is a perception out there that ACT teams are "housing addicts" and landlords and staff are less receptive. It is taking time for them to understand what we do.

According to Dana, the ACT teams' work is perceived by others as providing housing and support to "drug addicts," so landlords and staff at supportive housing sites are less receptive to ACT team clients who use substances. The participants stated that social exclusion and stigma also remain barriers to housing clients who use substances. Dana also noted that it takes time for housing staff and landlords to understand what the teams do to support clients with substance-use problems. Jackie, who worked in the region with an initiative that enlisted landlords to provide housing opportunities for homeless people, described the difficulty in securing rental housing for formerly homeless people who use substances:

> Landlords do not want to take clients who have been chronically homeless and using substances as tenants. They do not want to take people directly from the streets. But they [the landlords] will rent to people who have been stabilized in other housing previously [such as supportive housing sites].

Jackie experienced that some landlords were willing to rent to individuals "who have been stabilized" but drew the line at accepting individuals directly from the street. In 2011, a regional report stated that people with mental illness who were considered stable and could live in the community with the support of case managers were moved to landlord-managed apartments. People who had been chronically homeless and used substances (and who might also experience mental illness) were housed at supportive housing sites that were formerly staffed to support clients with mental illness. The participants found that the structure at supported housing sites was not always conducive to people who experience substance use issues, which could ultimately lead to the client's losing their housing.

Wishing. The participants expressed frustration that the housing rules at supportive housing were neither flexible nor centered on clients who use substances. Even low-barrier housing rules were criticised as "homogenous, not client centred" and focusing on clients who had mental health issues, not addiction issues. The participants expressed their *wish* that housing rules were client centred. Chris summarized these various criticisms:

> What I find is that housing aims is to be homogeneous, so to speak......everything has to be in this pigeon-holed little box, otherwise people [housing staff] become overwhelmed and they don't know how to work with the individual person. Then the person loses housing. It's a hell of a lot easier to work with something when everything's the same, everything needs to be these values, so it's—it's trying to make it that way.... [I]t is based on mental health, not addictions.

Some participants expressed the wish "to work with those setting the rules," or they wished that housing staff would be more "flexible" in their application of the rules. Alex pointed out that the ACT teams are not involved in setting up policies or rules, so they framed the issue of loss of housing as both "pushing the client back into harm" and "cultural safety," explaining that "there is a lack of understanding of where the person stands, their norms, what defines them. The[eir] cultural safety is being pushed away."

Alex said that in the past, the team would have generated a collaborative, "culturally safe" care plan focusing on challenging behaviour as it relates to the client's lifestyle and looking for points of connection by "identifying what the client's strengths are [so] that we [the housing staff, the client, and the team] can work within this situation." Chris and Alex described their wish list as including the ideal situation for not only working with those making the housing rules but generating a care plan based on an understanding of the person, their norms, and what defines them.

Although the ACT teams gather a vast amount of knowledge and experience in working with clients, the clients' norms are often not taken into consideration in the development of their care plan. There is a tendency towards paternalism, rigidity, control, and structure because the client is expected to conform to the rigid housing environment and the goals of the ACT program, and in the case of some clients, the conditions set by the ICS. Although there is no requirement to comply with treatment in order to be housed, organizational policies, rules, and practices—policy-based or otherwise—place many conditions on the client, who has little or no say or choice about them.

Chris and Alex both reported their experience of a trend to evict the client instead of working with them to address challenging behaviours. Furthermore, Chris and Alex both noted that there were fewer opportunities to spend the extra time required in these cases because tenancies at many low-barrier housing sites have been reduced from annual leases to tri-monthly or even monthly rentals.

The participants also raised a number of issues including the need for house rules and the flexible application of such rules in order to instil a client-centered approach. Problematic social behaviour that leads to eviction also results in social exclusion because the client then experiences discrimination and has difficulty re-entering housing. The lack of affordable rental housing and the small number of landlords prepared to take clients with a history of substance use exacerbate the difficulties in rehousing clients. “Supportive landlords” who have agreed to be part of the region’s initiative to increase the stock of rental housing stock are already housing stable mentally ill people. Clients “banned from everywhere,” that is, supportive housing sites, have limited choices.

Wishing includes the wish for a client-centered approach, flexibility in the application of the housing rules, and the generation of a care plan based on an understanding of the person, their strengths, norms, and identity. Fulfilment of these wishes in both the ACT and housing programs could narrow the variance and create an environment that supports clients to maintain housing, thus reducing the barriers encountered in Negotiating Re-entry.

However, a wish is missing. Rules pertaining to guests are identified as the most contentious and the main reason for housing loss. Making the wish and acting on it to include client involvement in setting rules promotes both the client’s inclusion in the process and their integration into the housing community. This would also serve to narrow the variance. The participants identified specific situations that they wished to change. However, underlying this wish is the need for a change in philosophy and approach. A philosophy that promotes housing retention and inclusion s reduces stigma (reduces) and the need to Negotiate Re-entry.

Hoping and praying. Two participants described that in situations where the team was down to the last housing options, they "prayed" and "hoped and prayed" that the housing agency and/or landlord would take their clients. Ray explained:

> People who have burnt so many bridges they do not have the ability to be more choosy, we can't say that we will not put them there, it is not the right setup, it's more like OK they'll have to take them, we have to put them there, there is no other option.

If a client "burns their bridges," the ACT team's options for housing the client are diminished. Because choice is considered a key component in a client's success in remaining housed, "burning bridges" inevitably leads to limited choices in housing placement. These considerations aside, the participants said that there are very few choices for clients who need "couples" housing and that there is a shortage of low-barrier and wet-housing for clients who use substances. Examples of "not the right set-up" include housing the client out of town, where rent is cheaper but where distance makes it difficult for the team to visit the client as needed. In addition, the client is further away from the services he or she needs, such as food banks and the needle exchange.

Limited options could result in placing a client in a building that is in poor condition. Participants described buildings run by "slumlords" as unsafe and unhealthy, having loose balcony balusters, stairs, and railings, visible mouse faeces, and cockroaches. Jayme said, "There are some places that we just will not and cannot use." Nevertheless, the participants described housing clients in places that were minimally furnished (i.e., bare light bulbs), in disrepair, or vermin-infested. Two participants on different teams were in the process of moving clients to other locations because of bedbug infestation. During one home visit that I attended, a client described killing "another" rat in his room.

The participants described many problems over which they have no control. Nevertheless, the teams expressed a pragmatic view of working with what they had in whatever situation they were in and doing what they could within the limitations of affordability, availability, and access. *Hoping and praying* and *wishing* that the situation could change reflects that in the prevailing system, there is a lack of affordable, adequate housing in the market rent sector and that accessing supportive housing for a small number of their clients is difficult.

The region's central committee process for placing clients in supportive housing further reduces the already limited rental market. My review of documents of the central placement agency that governs supportive housing sites revealed that clients are placed in housing according to their needs, not their choice. A wait-list is maintained and prioritized according to the urgency of the referral. Placement is decided by a selection committee that was described by participants as "knowledgeable and [having] experience of the population." The system was designed to be "fair and equitable," but it does not allow for choice, although the latter was established as a key element in HF programs. When the agency cannot place a client in housing, access becomes very difficult indeed, making it more likely that the client will remain homeless or use shelters, derelict buildings, or alleys—in other words, sleep rough. The team continues to work with these clients although the participants said that they knew that a minority of clients could only be housed in shelters.

Sheltering. Clients who can only be housed in shelters are sometimes described as refractory, that is, resistant to the effect of their antipsychotic medications. These clients experience severe mental illness and high levels of disability, often from the abuse of several substances. In a minority of cases clients are placed in shelters as housing staff fear they may jeopardise the safety of others. Clients who present as refractory represent a minority of those supported by the teams. Jayme explained that diagnosing and treating a mental illness is difficult when there is a comorbidity of substance use disorder and mental illness. In this case, supporting clients is clinically challenging. Jayme has many years of experience in working with clients who experience problems related to substance-use disorder and mental illness, believing that more education is required with respect to working with clients who engage in poly-substance use. *Sheltering*, as discussed by one program director and another participant, highlights the lack of hospital beds for mentally ill clients. This issue has been identified in both regional ACT and police reports. Another participant raised the question of the ethical provision of care in the community for severely mentally ill people who require hospitalization. This subset of clients is clinically complex, and the participants who discussed this feature were unsure about how best to support the housing of such clients. Thus, Negotiating Re-entry for these clients is very difficult.

De-housing. Three participants described the need to *de-house* clients for safety or because the client was using their home for illegal activities, such as drug dealing. De-housed clients were also placed in shelters. The teams do not abandon the client but continue working to stabilize them in the iterative process described in the section on Learning How (see Figure 1) by analysing what has and has not worked in Reinforcing Capacity and/or Enforcing Conditions. With this new experience and knowledge, both the team and the client continue to assess and reassess as they move forward.

The participants remarked that in most cases, a few attempts are necessary before the client transitions into being and remaining housed. The participants viewed each housing loss as an opportunity to review, recoup, and try again. The participants that I interviewed displayed the qualities of optimism, hope, and tenacity. They genuinely believed that there was always something that they could do for their clients and that "each day has to be a new day for our clients." The participants worked as a team to understand and resolve problems. They re-applied for housing placement in staffed housing through the centralized application process and searched for available rental properties for their clients. However, because gaining re-entry to housing was a challenging process, they expressed the need to *narrow the variance*.

Narrowing the Variance

Narrowing the variance concerns how the team negotiates the marginalizing factors that exclude the client from housing. The strategies for *narrowing the variance* include *guaranteeing intensive support*, *becoming housing site-centric, negotiating and overcoming marginalizing factors.* These strategies include capitalizing on the client's successes, coaching clients, and selling the client in an effort to negotiate the client's re-entry to housing. The process includes providing intensive support in order to ameliorate the issues that led to prior housing loss, rebuild trust with housing staff and landlords, and implement a new plan by building on success, acting on success, and becoming housing-centric.

Guaranteeing intensive support. One team prepares clients for tenancy interviews by coaching them. All teams help clients develop positive references and guarantee the payment of their rent. Most participants believed that, with guaranteed support and a formal plan to manage or resolve situations that led to prior evictions, clients would be more likely to be given the opportunity to be housed.

Housing agency staff often need proof that the team and the client have a realistic plan to ameliorate the issues that led to the prior loss of housing. Following through on that plan is essential to rebuilding trust. The participants worked to build on their successes, demonstrating that the client has the team’s support, so that housing agency staff and landlords would be more likely to negotiate the re-entry of other ACT clients into housing. The participants reported that in most situations, the agency placement staff usually responded positively when they knew the team was following up and providing support to the client. However, the participants also noted that it took time to build the relationship and for the role of the team to be understood.

An opportunity to demonstrate support, including the creation of a written plan, is provided on the referral form for supportive housing. The reasons for previous evictions must be identified, and there is space to propose solutions to previous problems. In the case of a client who has “burnt their bridges” or is “banned from everywhere,” the teams have fewer choices. Their options are to advocate for the client by providing a plan to manage the problem that led to housing loss, obtaining a bed for the client in a local homeless shelter, or finding market rental housing. It is sometimes very difficult to negotiate re-entry to housing for clients who have a long and problematic history of losing their housing. In explaining the role of the team in rehousing clients, Leslie referred to "various things for behaviour modification," alluding to the plan to ameliorate issues that led to the loss of housing:

> I think that because we provide such an intensive or assertive service, we've helped a lot of clients regain their opportunity for housing. For example, we have a client who was banned from everywhere. The only place that he could live was in a derelict building or somewhere in the alleys. He had been homeless and sleeping rough for ten years, and now that he is attached to a team, and we're assertive, we see him twice daily for meds [medication], we help him manage money, various things for behaviour modification. He has now lived successfully in housing for almost two years.

The team and the client work to ensure that the new situation will be different. To achieve a successful housing outcome, the team guarantees its intensive support through a combination of tasks, such as seeing the client once or twice daily, observing the client taking medications, and meeting with the housing staff on a regular basis to discuss any problems. The team's guarantee of support made it possible for Leslie's client, who had been homeless for ten years, to access housing and, with the team's support, remain housed. Many similar positive outcomes have been achieved. The teams build on successes with housing agencies and landlords, gaining their trust in the provision of client support. The team's guarantee of support made it possible for Leslie's client, who was "banned from everywhere" and had been homeless for ten years, to access and maintain housing. The participants described many clients who had experienced years of homelessness and who, after being rehoused a number of times, were now stably housed with intensive support. Ray described how his team and the client regained the trust of a housing provider:

> So this housing agency they kind of sort of trusted again and, I think because we're attached to him and we see him as often we do, they've given him a chance, so he's housed, successfully housed and with our support has remained housed.

Providing the client with intensive support helps the client remain housed. Working with both the client and the housing staff, the team deals with issues and crises as they arise. A system is set up to ensure that the client's rent is paid and the client takes the required medication. The process by which trust is regained includes providing clients with support that ensures behavioural change and compliance. Most participants believed that, with their guaranteed support and a formal plan to manage or resolve the situations that led to prior evictions, the client could be given the opportunity for housing.

Becoming housing site-centric. In negotiating the client's re-entry to supportive housing, the agendas of the team, the client, and the housing agency can be in conflict. The teams are focused on housing the client, whereas the housing agency wants to see compliance with the rules. Because not all ACT clients have mastered the skills of being a good tenant, the team works to pull the client toward meeting those conditions by Reinforcing Capacity and Enforcing Conditions, even though the client may require time to address challenges at their own pace (Belle Isle, 2013). Nevertheless, the teams do not give priority to the client's agenda.

As previously discussed, some rules at housing sites go beyond those of the Residential Tenancy Act. Guests can be restricted, alcohol and other substances are often forbidden, and smoking in the building is not permitted. Because most supportive housing sites are also workplaces, health authority rules prohibiting smoking apply. At some low-barrier housing sites, substance use is permitted, but no alcohol is allowed on the premises, and smoking is not permitted in the client's room.

Despite the region's claim of subscribing to the HF model, supportive housing sites are also run according to some aspects of the treatment model of care, including medication administration in-house, extra rules and regulations beyond those of mere tenancy, surveillance, and the threat of losing housing as a consequence of relapse, particularly in the case of clients who use substances. Although substance use is tolerated at some low barrier sites, it is not clear that HR services and education are provided. Belle-Isle (2013) stated that for HF to work, harm reduction measures have to be integrated into housing programs (p. 27). In Negotiating Re-entry to Housing, the development of a plan to support the client in staying housed shifts from being client-centered, and working from where the client is in life skills and substance use, to being housing site-centric. The focus is then on establishing the client's compliance with the housing site's rules. The team must negotiate the marginalizing factors and monitor and reinforce behaviour that complies with societal norms in order for the client to retain housing.

Negotiating and overcoming marginalizing factors. The participants expressed that they worked with their clients to overcome or *negotiate marginalizing factors* in obtaining housing, such as the client's appearance, presentation, and lack of references. The participants went further to include engaging in coaching the client through the interview process.

The participants on this team offered that they prepared their client for tenancy interviews because "potential landlords can be afraid of our clients, based on how the client looks and presents." To overcome this barrier, they use role modelling and rehearse self-presentation by conducting mock interviews, posing questions that are likely to be asked, and coaching the client through their responses. This approach also helps the client to develop interpersonal and communication skills. It goes beyond behaviour modification to reinforce the client's personal capacity, and it helps negotiate their re-entry into housing. Lee explained:

> [There is] a lot of teaching, mentoring and role-modelling with staff and the client on the different barriers that do come up....the client can have behaviours that can make people nervous. Sometimes, more than anything, it's just their appearance... So we're really upfront with them and then we role-model with them 'you want housing, here's what we gotta do'.

In this situation, the attempt is made to address a complex issue: social exclusion and marginalization. Lee's team works with the client, who for a variety of reasons might be unskilled or unaware of basic societal norms and hence could be disenfranchised from housing in landlord-managed buildings. Because mentally ill clients are often stigmatised by their appearance and presentation, a client could be refused tenancy because of these factors. The teams know that the stigma and marginalization of mentally ill clients continues to be a barrier to housing people with mental illness.

In *reconciling the variance*, Lee's team combines gaining access to housing with client education and reinforcing the client's capacity to meet the social expectations that are an unwritten condition of tenancy. This team specifically coaches clients who have severe mental illnesses. As discussed in the section on Reinforcing Capacity, this team has fostered relationships with landlords in the rental market sector. In fact, even if a particular client of this team loses their housing, the landlord is prepared to interview and select other clients proposed by the team. When I discussed the topic of coaching clients with the participants from other teams, they claimed that coaching would not work with a client that was independent, self-determined, and less directable, as substance users are. These participants discussed their continuing struggle to house clients who experience substance use issues; one described "selling the client" by promoting the client's positive aspects and promising team support to landlords. Despite these efforts, the variance is widened by the prejudice against people who use substances, but it can be narrowed through advocacy and fulfilled promises in client support.

The lack of appropriate references is another difficulty for clients. The lack of references widens the variance between the client's capabilities and their ability to meet the requirements of tenancy. The team narrows this variance by obtaining and providing client references. The participants spoke of the challenge housing clients who did not have references. For example, the team had to rehouse a client who was evicted for non-payment of rent. In this case, the landlord could not provide a positive reference. Fran reported discussing such difficulties with her team:

> Not only is there a lack of available housing, but we are unable to provide the new landlord with the right kind of reference that they want. So, because his [the client's] rent cheque bounced and the new landlord with the intent to rent contacted the previous landlord, he's gotten one bad reference. So now what we're working on is mending that relationship with the landlord so that he can provide a new reference that says, you know, "I...I felt like he was a bad tenant because his rent cheque bounced but the ACT team has figured out a way to get that money back to me so there are some checks and balances [sic] and you'll be okay if you have that person housed."

When they attempted to rehouse this client, the team stated that they would guarantee that the client's rent would be paid. The client in turn agreed to have the rent taken directly from his income source and to subscribe to the team's money-management program. Negotiations took place between the participant, the former landlord, the team, and the client. Further discussions took place between the team and a housing agency, in which the team advocated for the client and used the previous landlord as a reference. Providing landlords with a positive reference and guaranteeing rental payment both serve to narrow the variance, thus facilitating the client's Re-entry into housing.

Other participants described that the ACT teams guarantee rent payment by obtaining the client's agreement to participate in a money management program or by arranging that the rent money is deposited directly to the agency or landlord via the team, which ensures that the rent is paid. Two other participants reported that their team helped clients mediate a settlement with an agency or landlord by paying rental arrears or reimbursing damage to property. With regard to dealing with payment and arrears of rent, a financial aid officer at the relevant ministry is assigned to three of the four teams in order to expedite applications for monies. Jay used the term “breaking the silos” when reflecting on the advantage of having a person from the relevant ministry assigned to their team. In this case, the variance is narrowed at a systemic level. A barrier to accessing money for rent is removed because the client now has the support to complete the appropriate forms. The ministry’s financial aid officer was described by participants as knowledgeable and helpful in accessing rent stipends or housing subsidies for which the client may be eligible.

Summary of Negotiating Re-entry

Many ACT clients remain housed with the support of the team. Some ACT clients make several attempts before they settle into housing. The participants related experiences in which clients were evicted from housing for reasons that were usually related to the client’s current lifestyle, decompensation in their recovery from mental illness, or relapse in their substance use. The participants expressed that in struggling with the variance, the teams discussed the inability to intervene in situations such as the following: the client was evicted and the team was not contacted; a pending eviction is presented as non-negotiable; the client faces eviction because of illegal activities. The inability to intervene demonstrates the differing goals and the lack of collaboration between the team and housing staff or landlord. In these instances, there is no room to negotiate the tenant’s continued tenancy or re-entry to that housing site, which consequently reduces options for re-entry into housing.

Lacking a contingency plan is problematic when a client loses housing because of the relapse of mental illness or substance use. Because the team may focus on recovery, it has no contingency plan for clients who relapse. Hence, recognizing that relapse is part of recovery could contribute to keeping the client housed. Such recognition does not mean that the safety of others should be jeopardized, protecting the safety others was discussed in Reinforcing Capacity... However, if the specific focus of the region's plan is to implement HF in reducing homeless, and some clients who are being housed live with substance-use disorder, how this barrier is constructed within the context of housing needs to be both examined and reconfigured. Substance use is a barrier to both remaining housed and Negotiating Re-entry to housing.

Regardless of whether client behaviour is related to substance use, the participants expressed that they experienced a disciplinary divide between the ACT team and the housing staff. This divide is caused by their differing perceptions of the assessment and management of situations that occur with the client at the housing site, such as safety and aggression. Compromising the safety of others carries the ultimate penalty of eviction. When they are evicted, clients often face social exclusion and difficulty in being rehoused, especially when the clients are known to have a history of housing loss.

As the participants described struggling with this variance, they emphasised difficulties in housing clients in rental housing. Two described hoping and praying, whereas others perceived the existence of a "black book" of clients that were consistently excluded from both supportive housing and rental housing. Although in reality the black book does not exist, access to housing for such clients is restricted. Team members also expressed frustration with the homogeneity of housing rules and wished that they could have more say in the development of these rules and that rules and care plans were client-centered. The participants identified specific situations that they wished could change, which implied changing both the philosophy and its application by reducing the variance in barriers to maintaining housing and Negotiating Re-entry. Narrowing the variance concerns how the team negotiates the marginalizing factors that exclude the client from housing. Several strategies are employed to narrow the variance, including capitalizing on the client's successes, guaranteeing intensive support, overcoming marginalizing factors, coaching clients, and "selling" the client.

The participants work to negotiate marginalising factors by preparing the client for tenancy interviews. The team guarantees rental payment, arranges references, and advocates for the client. In the case of supportive housing agencies, the team negotiates re-entry into housing by providing a written plan to the central housing placement agency and guaranteeing their support of the client in resolving issues that previously led to housing loss. Participants and clients build on and promote their successes, thus increasing the likelihood that the client will be rehoused.

Summary of Key Findings

The Basic Social Problem: Variance

The findings showed that in their provision of support, the participants attempted to reconcile the variance between the client's characteristics and capabilities and the expectations and conditions the client has to meet to remain housed. The admission criteria of regional ACT teams allow them to support many clients who have experienced homelessness. The target population supported by the regional ACT teams is broad and highly heterogeneous. The participants identified that nearly all clients require intensive support to remain housed. The participants also stated that the client's characteristics and capabilities can either strengthen the client's ability to remain housed or increase their vulnerability to housing loss. These characteristics and capabilities are situated in the client's social history and life experiences.

The research participants worked to reconcile this variance by negotiating the presence or absence of a variety of factors: the client's capabilities; the relationship between the team and the client; the working relationships among the team, client, and housing staff or landlord; the willingness of the team and the housing staff or landlord to be creative, client-centered, and flexible in their support of clients; and the extent to which systemic and pervasive structural factors facilitate or hinder the client's ability to maintain housing.

The Basic Social Process: Reconciling the Variance

The categories of the basic social process of how ACT teams support vulnerable clients to remain housed arose from my grounded theory: Learning How, Developing a Therapeutic Relationship, Reinforcing Capacity, Enforcing Conditions, and Negotiating Re-entry. Reinforcing Capacity is the core category. The following is a summary of the key findings of the basic social process in this grounded theory study.

Leaning How

In *learning about the client* and *understanding the variance,* the participants identified the unique individual circumstances that contribute to the client's difficulty in remaining housed and that predispose the client to homelessness. In doing so, the team identified the client's vulnerabilities to housing loss and their specific housing needs. Although the participants discussed the need to focus on the clients' strengths, the participants did not easily or clearly identify those strengths as factors that might ameliorate a difficult situation or be used as a resource to help clients achieve their goals. Strengths were frequently provider-identified factors that promoted compliance with housing rules, societal norms, and being a good tenant.

In learning about the client and understanding the variance, the participants also noted that they and their clients had different perspectives about permanence, home, and ownership, which could influence how and whether the client engaged with and settled into their housing. The participants also expressed that both the clients and the dynamic in their housing situations change. Housing the client and providing support could be a process of trial and error. It might take two or three attempts before some clients remained housed. Thus, Learning How to support the client to remain housed is a reiterative process because the team continually reassesses both the client and their housing situation and takes the actions required to Reinforce the client's Capacity to remain housed. Ideally, the information and knowledge gained in Learning How informs the client placement in housing. However, Learning How cannot take place unless the team develops a therapeutic relationship with the client. Therefore, these processes are concurrent.

Developing a Therapeutic Relationship

The teams assertively engage and extend an arm of support to the client who is in crisis, stabilizing the client’s health, and attending to basic needs for shelter. The team members realized that they have to earn the client’s trust, so they work at establishing credibility *by* demonstrating to the client that the team is working in the client’s best interests. A continuum of the therapeutic relationship, and a desired outcome of the relationship, is supporting the client in self-care. This can often only be achieved once the client is housed and has overall stability in his or her life. With the information and understanding gained in Learning How and in the context of the Developing Therapeutic Relationship, the team works at Reinforcing the client’s Capacity to remain housed.

Reinforcing Capacity

The actions in Reinforcing Capacity are intended to mitigate the client’s vulnerabilities and encompass a range of strategies that includes interacting therapeutically. There are times when the knowledge gained in Learning How leads to a team’s restriction of a client’s choices and/or making a best-interest decision on the client’s behalf. Examples of best-interest decisions included the team—not the client—in decisions on the type and location of the client’s housing, placing the client on a money management program, and restricting guests. This paternalistic or maternalistic approach, with its emphasis on controlling the client’s behaviour, was perceived by the participants to be therapeutically advantageous and in the client’s best interests. Although from the team’s perspective, this approach may be client centered, it is not client directed. In the provision of care, the participants also exert control.

This focus shapes the participants' practice of acting in the client's best interests and making decisions for the client. For instance, the participants identified the principles of the client-directed motivational interviewing (MI) as foundational in their practice. The teams' best-interest decisions, however, are not client directed. Although the participants sought to be client centered in their approach and valued the promotion of autonomy, their practice shifted from focussing on the client to centring on housing placement. This happened when conditions extraneous to the Tenancy Act were placed on the client or when housing rules were either homogeneous and/or inflexible. In these situations, the support plan to help the client to remain housed became housing-centric, which insists on the client's compliance with conditions, such as agreeing not to have guests.

Another strategy in Reinforcing Capacity, harm reduction (HR), was identified by participants as informing their practice. However, I found that HR was not carried out to its fullest extent, as envisioned by the originators of this practice. In Reinforcing the client's Capacity to remain housed, the participants identified strongly with their roles as advocates and mediators. They mediated and negotiated the relationships among the team, the client, and housing staff, and the participants developed strategies to keep the client housed. They explained that housing retention is promoted by maintaining the relationship between these stakeholders and collaboration with them. Being client-centered, creative, and flexible were identified as factors that helped all parties to negotiate solutions to problems and issues that arose for the client at the housing site and increased the effectiveness of the team's support of the client. The relationship among the housing staff, team, and client became strained when perceptions differed on how to manage issues, including safety and management in situations such as relapse from mental illness or substance use, or the identification and management of aggressive behaviour. The sources of these discrepancies were identified by participants as the differences in the program focus of the ACT teams, the housing staff, and the staff's level of training.

The approaches to the provision of client support to remain housed in Reinforcing Capacity focused on promoting behavioral change by the client and/or reducing chaos to others.

Enforcing Conditions

Reinforcing Capacity is the core category of the basic social process of supporting vulnerable clients to remain housed. The regional ACT teams work with clients who are involved with the Integrated Court System (ICS), and collaborate with the ICS in Enforcing Conditions and determining the conditions, which might include court-mandated residence, oversight by the ACT team, or compliance with treatment for mental health issues. Enforcing Conditions compels the client to comply with the conditions set for community living and regulates behaviour. Hence, the teams *collaborate* with the ICS judge, which was considered by some participants as having the potential to erode the Developing Therapeutic Relationship and blurring the line between empowering clients to take care of their health and mandating that the client do so, such as by enrolling in an addictions treatment program. However, the participants reported that working with the ICS strengthened their capabilities to support the client to remain housed and complemented their work in this area. Enforcing Conditions ensured the client had a place to live and that clients were answerable for their behaviour, which helped the client to maintain housing.

Clients retain housing with varying levels and intensity of support. When some clients lose their housing, the participants then Negotiate the client's Re-entry to housing.

Negotiating Re-entry

Rehousing is considered part of the process of working with clients to maintain housing. In attempting to rehouse the client, the participants had to Negotiate Re-entry. *Collaboration* sometimes fails: the team did not have the opportunity to intervene or negotiate before an eviction. Although the participants initially stated that clients did not lose housing because of behaviours related to mental illness because relapse was a recognized part of the recovery process, they also discussed incidents in which clients were evicted because of their behaviour during decompensation from mental illness and relapse in substance use.

The participants also believed that some clients were screened out of the housing placement process. This pointed to both systemic and structural barriers to rehousing some clients. Structural barriers, such as the lack of both affordable housing and low-barrier housing, persist and make Re-entry difficult. The participants reported transcending the barriers between social services and health care by working closely with a Ministry of Health financial aid worker assigned to the ACT team. This relationship expedited the access to monies for rent, which possibly increased housing options. In Negotiating Re-entry, the participants discussed reducing the marginalizing factors that are barriers to housing access.

Chapter Five: Discussion

In this grounded-theory study of how ACT teams support clients to maintain housing, the findings clearly showed that the participants worked to resolve the basic social problem of how to reconcile the variance between the client's capabilities and characteristics and the conditions and expectations the client has to meet to remain housed. Client characteristics and capabilities are situated within the client's social context and life history. Many factors influence the client's capacity to remain housed and how the ACT team supports its clients. A set of conditions needs to be in place for the provision of effective support; nevertheless, there are both barriers and facilitators to this provision of support.

The studied ACT teams work with clients who are not only supported by other agencies but also by programs in systems that differ from the ACT teams, such as the Integrated Court System (ICS) and various housing programs. Conditions and expectations are placed on the ACT clients, and they must follow rules imposed by the different programs and housing agencies in the region. The participants also place expectations on the client and assertively engage them in therapeutic initiatives. The studied ACT teams encountered a number of challenges in their provision of support to their clients to remain housed.

The ACT teams nominally work within the HF context; however, structural challenges make this difficult for the ACT teams. I point out where the work of the ACT is and is not consistent with the HF philosophy, as well as the challenges encountered by the teams. Regional housing agencies and housing programs claim to use a HF approach. However, the findings showed that the type of housing and services provided do not always align with the HF philosophy. I will discuss these findings in the context of the HF literature. There is a lack of affordable housing in the studied region, which presents a structural challenge to the teams in their work to support clients to maintain housing. In the tight housing market, people who live with mental illness and may use substances are less likely to be prioritized by landlords for tenancy. I further discuss these findings in the context of the categories of the grounded theory,

In this chapter, I first discuss the findings that are consistent with the literature, followed by the findings that differ from the literature. I then identify the contributions this study makes to the literature, and I discuss the implications and make recommendations for research and practice. In the following section, I discuss the findings of this study that are consistent with the literature.

Findings Consistent with the Literature

Learning How

It sometimes takes two or three tries before a client remains housed. This experience, as reported by the participants, is consistent with the HF literature (Tsemberis, 2010; Pearson et al., 2007). The participants observed that it took time to learn how to support their clients, the type of housing that was best for their clients, and how long it might take their clients to settle into their housing. The participants described this process as one of trial and error. In my study, Learning How to support the client to remain housed was observed as an iterative process. Pearson, Montgomery, and Locke (2009) mentioned this aspect but it was not discussed in depth. The process of *assessing* the client and *understanding the variance* supports the learning of how best to support the client to remain housed.

In the process of Learning How, the participants recognised specific characteristics that increased the client's vulnerability to housing loss. These characteristics included poor interpersonal, social, and coping skills, and the inability to communicate needs or set boundaries. Such specific phenomena of client vulnerabilities to housing loss based on individual characteristics is not discussed comprehensively in either the HF or ACT literature. An exception is Macri (2010), who researched and developed a vulnerability assessment tool (VAT), which provided a structured method of measuring a homeless person's vulnerability to housing instability with the purpose of prioritising the client for housing placement. All the factors identified by the participants in my study are included in the criteria of Macri's method. In the case of the population of clients served by the studied ACT teams, it is clear that specific characteristics increase the vulnerability of a client to housing instability. Therefore, suitable individualised clinical services and social supports are required if clients are to maintain their housing.

The participants explained that an understanding of vulnerabilities helped them to *pre-empt potential problems* and inform strategies to support clients. This focus on vulnerabilities directs practice. However, although the participants were aware of the need to assess client strengths and vulnerabilities, the strengths were not clearly or easily identified. As discussed in *assessing* and *understanding the variance,* information about vulnerabilities is collected, but it is not collated in one section of a document or electronic client chart, and neither are the strengths of the client.

Reinforcing Capacity

My findings in the subcategory *interacting therapeutically* are consistent with the literature. The participants in this study assertively engaged their clients (Bond, Drake, Meuser, & Latimer, 2001; Burns & Firn, 2002; Chinman, Allende, Bailey, Maust, & Davidson, 1999; Chue, Tibbo, Wright, & Van Ens, 2004; Coldwell & Bender, 2007; Drake et al., 2000), ensured medication compliance, and managed the clients' finances. Money management is an evidence-based practice for ACT teams (Rosen, Carroll, Stefanovic, & Rosenheck, 2009; Swartz, Hsieh, & Baumohl, 2003) and is used in the context of HF programs to ensure that the clients' rent is paid (Pearson et al., 2007; Tsembris, 2010). The participants use the principles of Motivational Interviewing (MI) to support clients in their recovery from substance use and/or mental illness and to help them remain housed. The use of MI in working with clients living with dual disorders is also supported by the literature as best practice (Handmaker, Packard, & Conforti, 2002; Martino, Carroll, Kostas, Perkins, & Rounsaville, 2002; Steinberg, Ziedonis, Krejci, & Brandon, 2004). The ACT teams also use MI as a therapeutic strategy. MI was used in the inaugural PHF program and is a recommended strategy in the program guidelines for setting up a HF program (Tsemebris 2010). The studied ACT teams use MI in their practice, and they manage clients' monies to ensure that rent is paid, both of which are consistent with HF.

The participants' practice of MI theoretically supports them to focus on the client's strengths because aspects of this practice are philosophically underpinned by a strengths-based approach (Manthey, Knowles, Asher, & Wahab, 2011). However, there is tension between the participants' acknowledgement of the need to focus on strengths (as identified in Learning How) and their practice in the context of supporting their client to remain housed. This tension exists for a number of reasons.

Inherently, the focus on the client's vulnerabilities detracts from the client's strengths. As discussed earlier in Learning How, the participants identified that an understanding of the client's vulnerabilities to housing loss helped them to *pre-empt potential problems* and informed strategies to support clients to remain housed. The tendency of practitioners to focus on what is not working, to help, and to fix it is discussed by Gottlieb (2013). This focus results in viewing clients through a negative lens, which detracts from the assessment of client strengths. A conscious effort and a shift in thinking are required at the practitioner level to focus on, include, assess, and use a client's strengths consistently (Gottlieb, 2013) Using a strengths-based approach means that clients direct their care (Gottlieb, 2013; Rapp 2006); it does not mean that the vulnerabilities of the client are ignored but a balanced perspective of the client is required to promote recovery.

However, the studied regional ACT teams, like most ACT teams, are challenged in using a strengths-based approach in practice, as well as the consistent application of the principles of the principles of MI. ACT teams are situated in a medicalized context, which affects the way they work with their clients in relation to housing. This can make ACT an uncomfortable fit with the philosophies of HF.

Interacting Therapeutically

Inherently, the ACT team practices focus on managing the behavior of clients and the exertion of social control over the client's activities. This focus does not fit completely with the principles of MI, which are client directed, non-coercive, and non-directive (Miller & Rollinick, 2002), and consequently do not align with a strengths-based approach. To manage this tension, the team can identify and document client strengths and capabilities, bringing them formally and conscientiously bringing them to the forefront of team discussion when planning supportive strategies. The team can identify the principles of MI and keep them at the forefront of their practice and in their discussions about and with clients. The ACT program structure and inherent practice make it difficult for ACT teams to focus on a predominately strength-based approach and to use the principles of MI as expected of ACT teams that work within a program based on the HF philosophy (Tsemebris, 2010).

Although the participants' discussions and interactions with clients demonstrated that they promoted hope and respected the participants by using money management, assertive engagement, behavioral contracts, and limit settings to support the client to remain housed, social control is inherent in these practices, which was discussed in *providing structure* (Phillips et al., 2005; Stanhope, Marcus, & Solomon, 2009; Tschopp, Berven, & Chan, 2011; Watts & Priebe, 2002). The teams' current practices, which diminish choice, could make it difficult to apply the principles of MI and focus on the clients' strengths. These findings concur with those of Morgan (2008), who found that some ACT practices were barriers to the implementation of a strengths-based approach in ACT programs. The literature on the strengths-based approach, is largely theoretical and focuses on potential positive outcomes of recovery from mental illness.

The participants reported difficulties in balancing paternalistic/maternalistic approaches to letting clients make their own choices, and at the same time letting go of the clients' outcomes. Individual participants described working around this by reflecting on their beliefs and trying to consider the client's perspective. Although the participants did not frame this struggle in these terms, this ethical dilemma is frequently encountered by ACT teams in community psychiatry, and it is discussed extensively in the ACT literature (Burns & Firn, 2002; Gomoroy, 2002; Phillips et al., 2005; Stovall, 2001; Watts & Priebe, 2002). The participants further explained that they work through and resolve these questions as a team. The participants spoke of making best-interest decisions regarding where the client would be housed. They also discussed experiences in which some clients found it difficult to make choices and decisions. The direction the team takes and the extent to which it gives control to the client are based on their perception of risk to the client. The findings that the participants struggled with taking a strengths-based approach and promoting client choice in supporting clients to remain housed concurs with Slayers and Tsemberis (2007). According to the latter study, this tension arises because ACT program practice is inherently clinician-driven and medicalized. Slayers and Tsemberis (2007) further discussed that the need for a medicalized approach is because of the levels of disability experienced by the population. However they also advocate for ACT teams to be cognizant of their approach to care and focus on taking an approach, that promotes choice and includes a focus on the clients strengths.

The population discussed by Slayers and Tsemberis (2007) parallels that described by the participants, as well as the admission criteria used by the studied ACT teams. These include people who are frequent users of acute care services (in the case of the studied ACT teams detox, ambulance, police, and emergency room services) that include psychiatric hospitals are under the jurisdiction of the court, which mandates treatment in the community. Slayers and Tsemebris (2007) also identified some clients find it difficult to make choices and take control of their lives. As discussed earlier, the support provided by the team, the direction the team takes, and the extent to which it gives control to the client are based on their perception of risk to the client.

Social control is also exerted by the agencies with which the teams collaborate. The participants discussed working with clients to meet the conditions set by the ICS with regard to community living (e.g., engage in substance use treatment, reside where directed, and work with the ACT team). The participants also supported clients to meet the conditions of ongoing tenancy by the housing agency staff (e.g., no or limited guests and no alcohol on the premises). Collaboration with other agencies whose programs do not align with a strengths-based approach can mean the ACT team works with a deficit-based approach and thus encounters a barrier to full client support, as identified by Slayers and Tsemberis (2007). The barriers to focusing on client's strengths can be at the level of the individual practitioner (Gottleib, 2013), the team, the program (Morgan, 2008), and collaboration with other programs (Slayers & Tsemberis, 2007). The implications are that shifts in the perspective, policies, and practice of service providers are required at all levels of program delivery.

In supporting their clients to remain housed, the participants described the layers of control placed on clients at some staffed housing sites. The first layer that I observed was the surveillance and monitoring of clients, which aligned with the findings of Hope (2005), and the placing of clients in housing where the front entrance was controlled by housing staff. This arrangement was also discussed by Tsemberis (2010), who identified individuals who repeatedly lost their housing and "cannot manage the freedom of living independently" (p. 77), and needed to be housed "in a building with a secured front entrance." In the case of the studied ACT teams, clients who were considered vulnerable were placed in this type of setting.

The next layer of control described by the participants included the therapeutic strategies discussed in Reinforcing Capacity, such as *providing structure* by restricting guests and setting boundaries on client behaviour through the development of behavioural contracts. These strategies place pressure on clients to promote their own compliance with housing conditions and are in keeping with ACT practice, as discussed in the literature (Phillips et al., 2005; Stanhope, Marcus, & Solomon, 2009; Tschopp, Berven, & Chan, 2011; Watts & Priebe, 2002). Restrictions on client behaviour and conditions of ongoing tenancy are also placed on the client by housing staff (Allan, 2003; Parr, 2009; Wong, Poulin, Lee, Davis, & Hadley, 2008). The participants explained that for a minority of clients, these boundaries were set to protect the client and other tenants. All parties, clients included, often have different perspectives on safety and the degree of structure required. However, the participants discussed that for some clients, having rules and restrictions placed on them that were extraneous to the residential tenancy act put them at higher risk for housing loss because the conditions were too strict.

The participants also discussed that the issue of house rules, particularly those pertaining to guests, were clearly contentious for all stakeholders. Furthermore, the implementation and enforcement of rules extraneous to those of the Residential Tenancy Act were not in keeping with HF program philosophy (Tsemebris 2010). In supporting clients to remain housed, it was important to determine who is advantaged and disadvantaged by the various layers of control discussed, as well as the reasoning behind such arrangements. This warrants further study from the perspective of all stakeholders, including the valuable perspective of the ACT client/HF tenant I could not identify any studies that looked at the perceptions and experiences of clients supported by ACT teams at staffed housing sites. Hope (2005) examined the meaning of support in the term supportive housing and identified the extensive use of surveillance, but did not include the clients' perspectives. The ACT program has been identified as inherently coercive (Groton, 2001), although a study conducted by Tschopp, Berven, and Chan (2011) reported that ACT clients did not tend to see ACT staff as coercive in their practice. Moreover, they identified the pressure placed on them by ACT team members "as positive pressure rather than negative pressure" (p. 413).

Substance Use and Maintaining or Losing Housing

The participants supported their clients to maintain housing by using a range of approaches. During the data collection for this study, I visited clients who had severe mental illness and concurrently used substances, but who were stably housed and not in treatment programs. These findings are also consistent with the HF literature (Rosenheck et al., 2007; Stefanic & Tsemberis, 2007; Tsemberis & Eisenberg, 2000; Tsemberis, Gulcur, & Nakea, 2004). Many clients who lived with severe mental illness did not use substances and, with support, remained housed. However, the participants discussed numerous situations where substance use increased the vulnerability of their clients to housing loss, which is also consistent with the literature (Gonzalez & Rosenheck, 2002; Hurlbut, Hough, & Wood, 1996; Kreindler & Coodin, 2010; Lee, Wong, & Rothbard, 2009; Lipton et al., 2000;

Mares & Rosenheck, 2004; Pearson et al., 2007; Tsemberis, 2010; Tsemberis & Eisenberg, 2000). This raises the following question: Why do some clients supported by the studied ACT teams who use substances remain housed but others do not?

A number of factors were identified by the participants as making a difference between the loss and the retention of housing by clients. These include the client's housing placement.[3] Housing placement depends on the availability of suitable affordable housing, the ACT team's and the housing staff's approach to clients who uses substances, and clients' behaviour.[4] The participants also discussed having more power (or "more teeth") in their collaboration with the ICS[5] and the police in supporting their clients to remain housed. The willingness of agencies to re-house[6] a client who lost his or her housing was also a factor in whether or not the client was housed. In the context of these preceding factors, I will now discuss the question of why some clients who use substances remain housed and others do not.

Housing Placement

Despite the in-depth assessments carried out by the participants in Learning How, clients may be placed in housing that does not suit their needs. Assessing the need for clinical services and social support, and their provision is only part of what is required to promote housing stability. Quality, affordable housing suitable to the person's needs is also required (Canadian Mortgage and Housing Corporation,

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[3] Assessed in Learning How.

[4] Discussed in Reinforcing Capacity; *containing chaos, maintaining relationships and collaborating.*

[5] Discussed in Enforcing Conditions; *compelling regulating and collaborating.*

[6] Discussed in Negotiating Re-entry: *struggling with the variance.*

2001). The participants confirmed the lack of affordable rental housing and that landlords are reluctant to accept clients with a history of homelessness, severe mental illness, and/or substance use. In a tight housing market, where there is competition for housing, landlords are most likely to choose people that they consider the best tenants. Priority will not be given to be people who have issues related to substance use. This finding concurs with those of Kraus (2006) and the Canadian Mental Health Association report that substance use was the most common reason that landlords rejected potential tenants (Greenberg, 2007).

ACT clients who are placed on the regional central waitlist for housing do not have a choice of where they are housed. Choice has been identified as a key factor in the promotion of housing stability and is a principle of the HF approach (Rosenheck et al., 2007; Stefanic & Tsemberis, 2007; Tsai, 2010; Tsemberis & Eisenberg, 2000; Tsemberis, Gulcur, & Nakea, 2004). The participating regional ACT teams are challenged in their promotion of client choice because the regional housing placement system does not offer choice. This topic will be discussed further in the section describing findings that are inconsistent with the literature.

The participants identified a shortage of low barrier housing (LBH) for clients who use substances, which was also reported in the literature (Patterson et al., 2007; Pauly et al., 2011). The participants found that clients who used substances were less directable than clients who had a primary diagnosis of severe mental illness and were accustomed to being in the care of the mental health system. The participants further identified that clients who used substances were more sociable and more likely to have guests, and they were more likely to have restrictions placed on them with respect to guests.

Strict rules for limiting the number of guests, extraneous to the Residential Tenancy Act, can be a barrier to housing retention, a finding that concurs with the housing literature (Allen, 2003; Tsemberis, 2012). This issue was also discussed by Wong, Poulin, Lee, Davis, and Hadley (2008), who determined that housing staff exert behavioral control over clients through stringent rules. Undue emphasis on control at supportive housing [7] sites can be counterproductive, resulting in the loss of housing (Allen, 2003; Wong et al., 2008) and strain on the residential provider-client relationship (Wong et al., 2008). The participants reported that housing rules were contentious, particularly those restricting guests. The lack of appropriate housing, lack of housing choice, and extraneous rules are potential structural and systemic barriers to the housing retention of any client. The participants reported two examples of supporting their clients to remain housed when they worked with housing staff who took a harm reduction (HR) approach. To keep a client housed, collaboration between the team and housing staff is essential. I discuss these factors next.

Harm reduction. The participants described housing retention as being supported when the team and housing staff acknowledged that the client's substance use was not going to change. Instead of trying to make the client change, they adjusted the environment to reduce the disturbance of others. This would heighten the client's chances of retaining his or her housing while decreasing the number of negative consequences to the client and to others. These practices align with a harm reduction response. This is described in the subcategory *containing chaos* as consistent with the HR philosophy, which is a bottom-up approach. The client's choices inform the decision-making process (Martlett, 1996). Harm reduction is a core concept in the HF philosophy. It has been described as the key to success in housing clients (Tsemberis, 2010; Tsemberis, Gulcur, & Nakae, 2004) and therefore should be part of housing strategies (Pauly et al., 2011; Pauly et al., 2013). Harm reduction is an example of what works to support clients who are actively using substances to retain housing. Whether or not the housing staff are tolerant and practice harm reduction can be determining factors in the client's housing retention. Collaboration between the team and the housing staff also support the client to maintain housing.

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[7] Supportive housing sites being those where there are staff onsite

Collaborating. The key factors reported by the participants as promoting success in supporting their clients to remain housed were the following: both the team and the housing staff were client centered, collaborative, creative in their approach, and had a willingness to solve problems. These findings are supported by Tsemberis (2010) and Bebout, Drake, Xie, McHugo, and Harris (1997), who determined that the coordination of housing and service providers and being client-centered were absolutely essential to the provision of services to clients at risk of homelessness and who experience severe mental illness and co-occurring substance use disorder. These findings also concur with those of McHugo et al. (2004), who found that closer integration between clinical and housing services led to more time in stable housing for clients. As Scheyett et al. (2010) found, when good communication and collaboration exists, the teams are better able to support clients and ameliorate issues that arise within the housing situation. In the context of HF, clinical support is provided exclusively by the ACT teams, and housing is provided by the housing agency and staff.

Therapeutic relationship. When a client's tenancy was jeopardised due to substance use-related behavior or he or she lost their housing, the participants reported that they responded in a variety of ways. In line with Tsemberis (2010), the participants reported being non-judgmental, focusing the client on his or her goals, and using MI to help the client work through the problem. These measures are discussed in Developing a Therapeutic Relationship and Reinforcing Capacity. The participants also reported not giving up on the client and remaining optimistic. These practitioner qualities are also identified in MI (Manthey et al., 2011) as placing value on the therapeutic relationship and the team's support in *being there for the long haul*.

This discussion was framed by the examination of why some clients who use substances remain housed but other, similar clients lose housing. The factors that facilitate housing retention or are barriers to it are the same, whether the clients use substances or not. These barriers and facilitators can be diverse: the type of housing in which the client is placed; the appropriateness of the housing to the client's needs; the support practices of the housing staff; and whether these practices include harm reduction. The participants reported that the successful support of clients to remain housed requires the team and the housing staff need to be client centered, collaborative, creative, and willing to solve problems. These finding concur with (Tsemberis, 2010). However, these conditions are not always in place. The participants further reported that the qualities that they required and aspired to included being optimistic, non-judgmental, optimistic and not giving up on the client. They identified that that it was important to manifest these qualities and to continue to develop the therapeutic relationship with all clients. The participants described that they worked with clients who had difficulties maintaining housing because of substance use-related behaviour and activities.

Client behaviour. The findings showed that disruptive or illegal behaviour related to substance use was a strong differentiating factor in housing retention or loss. The participants specifically identified behaviour that infringed the rules of the Residential Tenancy Act or broke the law, leading to loss of housing. Housing loss in this context was identified by Tsemberis (2010) and mentioned by Pearson et al. (2007). Tsemberis (2010) reported a failure rate of 10–15% in the Pathways to Housing Program (PHF) because of excessive alcohol or drug use. Tsemberis explained that housing retention becomes an issue when the client's primary goal is substance use. In this case, the latter takes higher priority than the responsibilities of tenancy, which the client starts to neglect. The participants identified this as the case for a small group of few clients who could only be placed in shelters because of the common factor of their poly-substance use. If the client engages in illegal behavior or breaks the rules of the Residential Tenancy Act, they will be unable to retain their housing.

In the scenarios discussed by the participants, substance use could range from being non-problematic to being harmful to the client and disruptive to others. Illegal activity and disruption has been described as antisocial behaviour and was discussed extensively in the studies related to social housing in the United Kingdom (Parr, 2009). These concerns are dealt with through policies that legislate increased power for landlords and housing support staff and criminalize the behaviour of tenants (Parr, 2010; Wilson, 2013).

Working with the Integrated Court System. The participants described working with the judge in the Integrated Court System (ICS), noting that when clients engaged in illegal activities, they would be held accountable to the judge for their behaviour. The participants would become involved, bringing the behaviour to the attention of the ICS judge (see Enforcing Conditions). In the case of some clients, this helped support them to maintain their housing. Some participants believed that the work of the ICS complemented their work with the clients, which aligns with the literature. The premise of this type of Canadian court is that the law is administered such that it incorporates therapeutic goals (Schneider, Bloom, & Heerema, 2007). According to the participants (and regional court reports), the team members and clients discuss goal setting with the judge. Positive outcomes have been reported through the collaborative efforts of ACT teams and courts with respect to decreased substance use and crime rates (Cosden, Ellens, Schnell, Yamini-Diouf, & Wolfe, 2003). These positive outcomes were also identified by the participants and in regional court reports. Some participants described bringing a police officer to clients' apartments to warn them about their behaviour (discussed in Enforcing Conditions).

Conversely, other participants identified the affiliation with the court and the police as potentially eroding Developing the Therapeutic Relationship. This was reported in both the regional ICS report (2011) and the regional ACT team report (2012). [8] There is limited research on the client's perceptions of working with ACT teams within the criminal justice system. The participants considered that collaboration with the ICS, appealing to the authority of the judge, and developing a collaborative support plan all promoted the studied teams' ability to support this client group to remain housed.

Willingness to re-house. The participants described advocating for their clients and being able to negotiate access to housing, thus affording the clients a second chance. These findings concur with those of Scheyett, Pettus-Davis, and Cuddeback (2010). The participants also found that it was difficult to re-house some clients who had a history of substance use or were labeled by housing providers as difficult. The participants perceived that some clients had been screened out of the housing process. Tsemberis (2010) also identified this tendency, stating that screening should be employed only to ensure that the most vulnerable people were housed, not to screen out people who were likely to fail. Therefore, screening clients in this way is contrary to the HF philosophy. Gomez, Hilario, Corbett, and Weeks (2007) used the term "creaming" to identify the practice of excluding people from housing. The region under study uses a centralized placement process for housing people. This process is intended to foster equity and fairness in entry to housing in a resource-constrained environment. However, it fails to be equitable if some clients are not housed. The perceived practice of screening clients perpetuates social exclusion, stigma, and the homelessness cycle. Structural and systemic barriers exist for housing clients who live with substance-use disorder.

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[8] Report titles are withheld to protect the confidentiality of the participating teams.

Findings Inconsistent with the Literature

In this section, I discuss the findings of my research study that either diverge from the literature or are not clearly discussed in it. The findings that diverge from the literature were mainly in the category Reinforcing Capacity and included the topics of harm reduction[9] and the tripartite relationship.[10] In this section, I also examine and discuss the findings that are inconsistent with the literature with respect to the participants' work in the context of HF. The findings regarding the participants' experiences showed areas where the work of the ACT teams to support clients to remain housed were inconsistent with the HF approach. Structural challenges made it difficult for the ACT teams to work in a way that was consistent with HF. Structural and systemic factors impeded the teams' work to break the cycle of homelessness. Furthermore, although the regional program is called housing first, it does not necessarily align with the HF philosophy.[11] For example, although the HF philosophy includes harm reduction (HR). The findings of my study showed that the ACT teams did not practice HR to the fullest extent in supporting clients to remain housed.

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[9] Reinforcing Capacity; subcategory *interacting therapeutically*

[10] Reinforcing Capacity; subcategory *collaborating*

Harm Reduction

The lack of focus on HR to its fullest extent means that the work of the ACT team is inconsistent with HF practices (Tsemberis, 2010). The participants noted that loss of housing pushed clients back into harm and that being housed promoted clients' health. Pauly, Reist, Schatman, and Belle Isle (2013) identified the need to address homelessness. Although the participants took sharps containers to clients' homes or removed full containers for incineration, they did not provide clean needles, supplies, or education about safe injection and vein maintenance. For example, if a client had an abscess and required education and treatment, he or she was referred to a nurse practitioner. The participants reported being told that they could not provide clean needles or HR supplies or assist the client in choosing safer options for alcohol consumption, such as low-alcohol beverages or alternatives to alcohol-based medications or products not intended for consumption.

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[11] Negotiating Re-entry

This finding is inconsistent with the harm reduction literature that is specifically related to harm, such as overdoses, abscesses, and cellulitis, sepsis, HIV, and Hepatitis C in clients who are unwilling to discontinue their substance use (Hunt, 2003; Kerr et al., 2004). The participants provided examples of behaviour that could be ameliorated by using simple harm reduction strategies. Some team members felt that they were constrained in their practice of HR and were unsupported by both their managers and the health authority. This lack of support should be addressed by managers and the health authority at the level of program delivery. Both levels should support HR practices by educating team members about this public health strategy and by providing access to HR supplies (Pauly et al., 2013). The lack of HR practices with clients unwilling to discontinue substance use is not consistent with the HF philosophy, which embraces a HR approach (Tsemberis 2010; Tsemberis, Gulcur, & Nakea, 2004)

The participants discussed the use of HR practices as a therapeutic approach. It is interesting that the BC ACT Guidelines do not include HR in its list of support services for clients with substance-use disorder. However, the support services do include assessment, motivational interviewing, and active treatment, such as counseling and community reinforcement (van der Leer et al., 2008, p. 34). Because the theoretical basis of ACT does not include a philosophy of HR, it was not part of that model. However, the studies I reviewed sought to establish the efficacy of substance use treatment (Fletcher et al., 2008). Moreover, some research advocated substance-use counseling by the ACT team (Essock et al., 2006; Fletcher et al., 2008), noting that ACT teams strived to provide a recovery-oriented approach. However, my findings showed that the participants in the regional ACT teams stated that although some clients received treatment, others used substances and did not seek treatment. Additionally, the participants said that some clients were too restless to sit still and participate in the sessions held in the communities' outpatient addiction services, or they had been banned from the meeting. Nevertheless, wherever clients are on the continuum of substance use, they could benefit from the HR approach, which does not preclude treatment or abstinence if and when clients choose these options. There is a significant opportunity for the ACT teams to demonstrate leadership in HR practices (Pauly, Reist, Schatman, & Belle Isle, 2010) because they already develop therapeutic relationships with clients in the population at the highest risk.

Housing First and the ACT Teams' Experiences

The participant's reports of their experiences in working with their clients to maintain housing demonstrate that the regional housing program does not wholly align with the HF philosophy. In their work with clients to maintain housing the studied ACT teams are challenged in being consistent with the HF approach. The area of greatest a mal-alignment between the studied ACT teams and the HF philosophy are in housing choice and the acceptance of treatment; choice in these areas are core to the HF philosophy (Tsai, 2010; Tsemberis, Gulcur, & Nakae, 2004).

The ACT teams provided very little choice in housing for a number of reasons. There is a lack of affordable housing, even with availability of rental supplements, this challenges the ACT teams in offering their clients choice. In a tight housing market, landlords would take the most desirable clients, and people who live with mental illness or are known to have a history of substance use are less likely to be prioritised by landlords for tenancy. The ACT teams may also diminish client choice in location or type of housing, by making a best interest decision on behalf of the client.

In these type of situations where there is a lack of affordable housing, or best interest decision is made by the team for the client, the team are challenged in aligning their work with the HF program philosophy in respect to providing choice. The HF philosophy also emphasises that the client has choice in accepting treatment. The regional ACT teams assertively engage clients, particularly those who do not want to engage, and the teams work with a minority of clients who are mandated to work with them through the ICS. In these situations choice in the acceptance of treatment and housing are diminished. Housing agencies may also place rules extraneous to the tenancy act on the client as a condition of tenancy. The team will work with the client to ensure rule compliance and housing retention. In some cases clients gain access to housing because the ACT teams support the client and having a treatment plan increases the possibility of client access.[12]

The work of the studied ACT teams is in inconsistent with the HF philosophy. The medicalised program structure of the ACT team, the lack of affordable housing, and the demands placed on the clients' by the agencies impact how the ACT teams work with their clients in the context of housing, Thus challenging the teams in being consistent with the HF program. ACT teams who are partnered with an agency who subscribe to the HF philosophy have to adjust their program (Tsemebris 2010). These changes include promoting client choice in housing and treatment, supporting a HR philosophy and having a program that is client driven (American Psychiatric Association 2005; Matejkowski, & Draine 2009; Tsemberis 2010). As previously discussed ACT teams encounter barriers in doing so (Matejkowski, & Draine 2009; Slayers & Tsemebris 2007;Ackerson & Karoll 2005). From this perspective ACT is an uncomfortable fit with HF as described in the literature. Despite working in a region that claimed to use HF in their provision of housing services the regional ACT teams did not ascribe to a HF philosophy and most participants were unclear on the HF program concepts.

The participant's reports of their experiences in working with their clients to maintain housing demonstrate that the regional housing program does not wholly align with the HF philosophy. Pleace (2012) identified inconsistencies in the uptake of the HF program in different countries and regions, using the term "model drift" to indicate that alterations in the model may not maintain fidelity to the core principles of the model. Pleace identified some programs as housing-led instead of prioritizing housing first, showing that not all HF program elements were applied, even though housing was provided without the client's acceptance of treatment for substance use or mental illness.

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[12] Negotiating Reentry

The model drift of the HF program in the studied region is significant compared with both the inaugural PHF model (Tsemberis, 2010) and the recently developed HF fidelity index (Watson, Orwat, Wagner, Shuman, & Tolliver, 2013). The discrepancies include the following: screening; constraints on rapid rehousing; the lack of choice in treatment and housing; housing permanence; community integration; the separation of the roles of housing staff and housing management form the clinical role of the ACT teams or client case managers; the separation of treatment and support in housing; and HR practices.

Model drift can be caused by a lack of affordable housing, as is the case in this region, or political and budgetary constraints. As previously discussed, choice in housing and acceptance of treatment is provided; choice is one of the primary principles of the HF model. In the classic PHF model, the type of support provided is client-driven; HR is both a philosophy and practice; housing is permanent (Tsemberis, 2010; Watson et al. 2013); and the roles of housing staff and the ACT team are separate, the former providing housing support and the latter providing clinical support (Tsemberis, 2010).

Screening and rapid re-housing. The participants perceived that some clients were screened out of the placement process if they were labelled as difficult to house or had had prior difficulty being rehoused. Screening should be carried out only to ensure the most vulnerable people are housed, not to eliminate people who are likely to fail (Tsemberis, 2010, pp. 18–19). In the studied region, long waitlists and the lack of affordable housing mean that rapid re-housing cannot easily take place when a client loses his or her housing. This increases the client's risk of re-entering the homelessness cycle.

Choice. The lack of choice in housing could mean that the team works to fit the client into available housing, instead of housing appropriate to the client's needs. Freedom of choice in housing has been linked to greater client satisfaction and housing stability (Tsai, 2010; Tsemberis, Gulcur, & Nakae, 2004). Lack of choice could therefore predispose clients to housing instability. In this regional study, I found that the variance between housing needs and housing placement could increase the vulnerability to housing loss, particularly of clients who required couples housing, low-barrier housing, or who were placed at sites with more or less structure than the client required. Occasionally, a client's needs change between the time of assessment and the time of housing placement. The participants expressed a desire for more say in where a client is placed, noting that it also took time to know their clients, learn how best to support them, and determine the type of housing that would be of the greatest benefit. Assessing the clients, learning about them, and understanding the variance by grasping the history yielded important information that did not always inform housing placement.

The participants worked to support their client in housing whatever the placement. Opportunities to try again were presented when the client was evicted. The teams took a pragmatic approach in such situations, believing that the housing situation would eventually be resolved and that they needed to educate and support clients in their current housing situation. This individual approach, which is inherent in the work of the team, placed emphasis on the client to change and adapt.

Community integration. A goal of the HF program is community integration, that is, the inclusion of clients with mental illness in the community. The founder of the inaugural PHF program contended that no more than 15% of any building should be tenanted by HF clients. Community integration should be promoted and the consumer's preference to have an apartment of their own respected, instead of segregating and socially excluding people with mental illness by grouping such individuals in one building (Tsemberis, 2010). In my regional study, at one staffed housing site, more than 90% of the building was tenanted by people housed through the HF program and supported by ACT. At another site, almost all 36 tenants had been housed through the HF program were supported by an ACT team.

Housing is designated for people with severe mental illness and/or addictions and a history of homelessness. However, these criteria for entry lead to the congregation of such individuals in the same building, which does not allow for the geographical integration of individuals into the community. However, in this region, buildings vacated by clients with a diagnosis of mental illness have become available to people with a history of homelessness.[13] In addition, buildings have recently been renovated to house this population. These are huge steps forward in the political will to make housing available.

However, vestiges of the treatment model of care persist within the housing context. The on-site staff in several buildings in the region have a clinical role, such as administering medication. These staff include licensed practical nurses, RNs, and support workers with training in mental health and addictions. It is not clear why both on-site and community support by the ACT team are provided simultaneously or at what expense. Hence, there are apparent inefficiencies in the provision of support services.

Separation of treatment and support. This arrangement also conflicts with the PHF model's expectation that the roles of the staff in the HF program need to be separate from those of the ACT team staff or other case management services (Tsemberis, 2010; Watson et al., 2013) and that housing should be separate from treatment (Padgett, 2007; Tsemberis, 2010; Tsemberis et al., 2004). Nevertheless, the separation between these two types of providers should be maintained because it can become increasingly difficult for clients to develop trusting relationships with the ACT team members when the lines between the roles of the ACT team and housing staff become blurred (Watson et al., 2013, p. 7), when role conflict arises and the team have and housing staff have different disciplinary approaches. [14]

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[13] This was reported in the local newspaper and online forums debating this initiative

Collaboration. Previous studies identified the need for ACT team members and housing staff to pre-empt frustration by being open and transparent in discussing their concerns and priorities (Tsemberis, 2010, p. 65). The tripartite relationship (i.e., team, client, and housing staff) experienced by the participants is not specifically discussed in the original Pathways to Housing First (PHF) literature. The PHF program clients lived independently in PHF-provided apartments and without on-site clinical support staff (Culhane, Metraux, & Hadley, 2002). The ACT teams in the PHF model took full responsibility for the clinical support of the clients (Tsemberis, 2004; Tsemberis, 2010). Roles were clearly specified and the housing and clinical domains were completely separate (Tsemberis, 2010, p. 23). Even with this clarification of roles, the PHF partners had to take steps to reduce frustration.

In the studied region, in some instances the ACT teams provided support to clients at housing sites where there were on-site clinical staff. The roles of the ACT team and the housing staff should be separate, not only to promote collaboration but also to maintain and promote trust within the ACT team–client relationship, in which a high level of collaboration is required among service providers. Each program (i.e., HF and ACT) has different priorities, which could lead to conflict in the provision of support.

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[14] Discussed in Reinforcing Capacity within the subcategory Collaboration

Issues with collaboration and communication were discussed in Reinforcing Capacity. Kloos, Zimmerman, Scrimenti, and Crusto (2002) described how conflict is inherent in the landlord-care provider relationship (in the case of this study, the housing staff/ACT relationship) because of the nature of their roles: each party has different interests. The participants acknowledged that housing staff were tasked with keeping the peace at a housing site of 35 tenants, where as a whole team to looked after the client. However the participants at times were frustrated by the inflexible and homogenous rules. Tsemberis (2010), in his guidebook for organisations learning how to implement the HF model, stated that for the ACT team/housing staff relationship to work well and to manage frustration when things were not going smoothly, both parties must be open and transparent, and they must fully discuss their concerns and priorities. Differing priorities, role conflict, and disciplinary perspectives on issues such as safety emerged as barriers to collaboration. At times, the participants had different views about how situations should be managed because they knew the client and had different disciplinary perspectives. Situations included client relapses in mental health, substance use, or a belief by team members that staff sometimes perceived clients as being aggressive because they were rough and loud but in the participant's opinion were not a threat. According to Tsemberis (2010), the housing agency staff and the ACT team need to be highly coordinated and therefore should meet weekly (p. 65). In my study, meetings between the participating ACT teams and housing staff generally took place only when problems or issues arose. One participant believed that meetings should take place on a more regular basis. A housing staff member described team members coming to the housing site to drop off blister packs of medication for ACT clients residing in the building but not speaking with the staff about the clients. Two housing staff members said that they had to be assertive in getting the team member's attention, thereby identifying a lack of collaboration. This issue needs to be addressed at the inter agency level the participants clearly described situations when collaboration worked and the client benefitted, however there are a issues that need to be addressed if the cycle of homelessness is to be broken for the clients who remain highly vulnerable to housing loss.

In Learning How, the participants acknowledged their need to focus on *assessing* the client's strengths as well as their vulnerabilities. In the context of supporting the client to remain housed, strengths were not easily identified. Instead, the assessed vulnerabilities of the client directed practice. In the studied setting, no formal mechanism was in place to identify and incorporate strengths into practice. Furthermore, the findings showed dissonance between the knowledge of and desire to focus on client strengths and their potential to do so in practice.

The need to focus on clients' strengths is clouded by the perceived need to redress the client's vulnerabilities (Gottlieb, 2013), the practices within the regional ACT teams (Morgan, 2008), and the team's work with other agencies that impose structure and control on the clients (Slayers & Tsemberis, 2007). Because of program practices, the shift away from clients' strengths occurs at the levels of provider, team, and interagency. To address this issue, it is important to examine these practices and become aware of the sources of tension. The participants collected a vast amount of information about the clients during their assessments in Learning How, but this information was not always channelled to inform housing placement. This issue, which is system-based, could be addressed, with a view to balancing vulnerabilities with strengths.

Developing Therapeutic Relationships

The participants identified the importance of the therapeutic relationship, and highlighted relevant aspects, such as not giving up on the client, being optimistic, and *being there for the long haul*. The participants were strong advocates of their clients and were genuinely concerned about their well-being. Two participants were concerned that their work with the ICS could erode their relationships with their clients. Other participants described situations in which the client had broken the housing rules, and the team were called to "mete out the consequences to the client." They did not believe this was within their jurisdiction. The common factor in these situations was that the participants were tasked with enforcing conditions set out by a third party. The team members expressed concern that this could negatively affect the therapeutic relationship.

Reinforcing Capacity

A significant finding in this category concerned tensions in the teams' HR practice. The participants did not provide harm reduction supplies or education to their clients, despite daily and/or weekly contact with them. Although there would be many advantages to providing this important public health service to the population served by the team, the participants reported being constrained in doing so. Integrating a full continuum of HR in an evidence-based practice should be addressed at all levels of policy. I address this in the section on implications for practice.

Maintaining relationships among the team, the client, and the housing staff were identified as paramount in supporting the client to remain housed. Also identified as barriers to collaboration were differing priorities, role conflict, and disciplinary perspectives on several issues, such as safety. These issue are systemic instead of interpersonal and therefore should be addressed at the systems level.

The participants' accounts of their experiences in working with housing agencies that claims to be in the HF program showed that the housing agencies, in many cases, did not use a HF approach. Comparison of the participants' experiences with the HF fidelity scale and HF program philosophy, identified discrepancies that could potentially raise barriers to housing retention. Because the regional program is evolving, the findings of this study could add to the existing knowledge and significant work that has been done in this area.

Enforcing Conditions

This complex topic was explored solely from the perspective of supporting clients to maintain housing. However, the participants believed that working with the ICS supported them in their work to support clients to stay housed, although I did not have access to supporting statistics. The court mandates the client’s place of residence and his or her participation in treatment. One participant used the term *blurring the lines* between the clients’ autonomous decision-making and their response to instructions. Some participants worried that these blurred lines could lead to a regression in the therapeutic relationship between the team and the client. These concerns further highlighted the ethical dilemmas encountered by the teams.

Negotiating Re-entry

A significant finding concerned the teams’ perceptions that some clients were being screened out of housing placements. In *struggling with the variance*, the participant’s described incidents of a client’s sudden loss of housing, which showed that the cycle of homelessness was perpetuated for some clients. A small group of clients can only be housed in shelters.

Implications for Policy Practice and Research

There are implications for policy and practice within the ACT program and at the levels of the health authority, interagency, and the regional housing program. In Developing a Therapeutic Relationship with their clients the ACT teams strive to be non-judgmental, client centered and respectful in their provision of care to their clients, advocating and supporting them. They use various strategies to Reinforce the Capacity of clients to remain housed. In doing so they reduce barriers to housing and improve housing stability. In this section I discuss the implication for policy within each of the categories of the grounded theory of how ACT teams support clients to maintain housing.

Learning How

Assessment tool. Macri's[15] Vulnerability Assessment Tool (VAT) is designed to screen and prioritize the placement of clients in housing to determine which clients are the most vulnerable in respect to their overall health. The vulnerabilities for housing loss described by the participants were also identified in Macri's VAT. It would be worthwhile to develop a similar tool that provides a framework to assess client vulnerabilities for housing loss and the client's strengths. This would allow the formal collation and documentation of this information in one place in the client chart to more comprehensively inform practice. Further research and testing would be required to develop this type of comprehensive assessment tool.

Reinforcing Capacity

ACT program support. It is important to create opportunities for the ACT teams to share their experiences with each other and to share creative strategies to solve problems. The ACT team are working with a complex heterogeneous population of clients and their approach is inherently medicalised. As the whole team support the client each team needs to be examine their approach to their provision of housing support. The strengths based approach provides a lens and perspective to look at the client, and Motivational Interviewing provides the principles for framing an approach that explores the client's goals.

ACT teams need support to consciously promote client autonomy and choice; as previously discussed the teams encounter challenges in doing this. Participants are trained in Motivational Interviewing and many are cognizant of the need to take a strengths based approach to care. It is important to forefront these skills. This can be done by first formally identifying how they operationalize in practice, then making a conscious effort during each interaction, either within the team, or between team member and clients to consistently apply the principles of MI and the perspective of a strengths based approach.

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[15] Learning How

According to current literature ACT teams are encouraged to make a paradigm shift to a more client-directed approach to care (Tsemberis & Slayer, 2007), and recovery-oriented psychiatrists advocate for policies to promote client choice (Ranz & Mancini, 2008). Recovery orientated practice focuses on client strengths and promotes choice but must not ignore vulnerabilities. There is a shift away from the approach of the treatment-based clinician as expert to a more client-centred approach (Tsemberis, 2010; Tsemberis & Slayers, 2007). ACT teams need support from within the team to consciously promote client autonomy and choice and to make this shift.

It is important for ACT teams members to openly discuss the tensions within their practice and have forums in which to identify solutions. A very experienced participant identified the need for support and education in working with clients who engage in poly-substance use. The teams do not have a person who can be an expert resource for information on substance use, although the team psychiatrist may fill that role in some teams. Further suggestions and discussions with the team are warranted to identify how best this support can be best provided. The regional ACT teams do not have the opportunity to meet to exchange experiences, ideas, and practice issues and this should be facilitated.

Harm reduction. There is a need to advocate for operational policies which support Harm Reduction practices. The lack of HR service needs to be addressed by managers and the health authority, and at the level of program delivery and policy. This means providing both education and HR materials; these are readily available to health professional in this province from the BC Center for Disease Control. Participants observed that some clients were not welcome at the local community addiction centre, as they could not sit through the sessions or were considered too disruptive.[16] These observations further highlight the importance of initiating a full harm reduction program. HR is a beneficial and cost effective service. There is a need to advocate for operational policies that support harm reduction practice. By providing a full range of HR services, the teams would be better able to support their clients, reduce social stigma, and lower barriers to HR services. Integrating the full continuum of harm reduction as an evidence-based practice needs to be addressed at the provincial policy level and through policies set by the health authority. Further research on how HR can fit with the ACT program structure, fidelity standards, and the barriers and facilitators to the implementation of HR in this region is warranted.

If HF is to be fully implemented in the region staff must learn embrace a HR approach. Although there were sites where staff practiced HR effectively promoting housing retention, it is not clear that HR was practice at all sites that housed clients with co-occurring disorders. This calls for the promotion of HR practices through policy and education.

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[16] Reinforcing Capacity

Housing First

The studied ACT teams work to support their clients to maintain housing in a region that nominally subscribes to a HF philosophy. HF is a program model, a philosophy and it is also a policy (Cullhane 2011). In some contexts the implementation of the regional ACT program model and service philosophy diverges from that of HF and there are vestiges of the treatment model in housing. To support a shift from a treatment based model of service provision and adjustment to the provision of services that promotes client choice, housing staff need to be educated about the philosophy of HF, including, for example, such facets as housing being a human right, rather than a privilege, and not something that is earned by compliance with treatment and rules (Tsemebris 2010 p. 170). How the HF model is to be (or is being implemented) in the region needs to be clearly defined in regard to the implementation of the program model and philosophy and policy development.

Collaboration implications for all stakeholders. An environment is required that promotes and advocates for the inclusion of clients/tenants to have a voice to share the power of decision making (Pauly , Reist and Schtaman 2013)**,** this can be created by housing program administrators. There needs to be a shared model, vision, and philosophy of care that fosters collaboration between housing agency staff or landlords, clients, and the ACT teams. This model must be consumer driven (Stefanic & Tsemberis, 2007; Tsemberis, Gulcur, and Nakae, 2004). A forum is required where the teams and housing agency staff can evaluate and discuss issues of impeded communication, jurisdictional or role conflict, differing priorities, divergent philosophies, and perceptions of safety. Policy and practice guidelines could be drawn up in consultation with housing staff, team members, and clients with a view to creating partnerships and *maintaining relationships* to promote housing retention and to effectively break the cycle of homelessness. Further research is required as to the housing staffs perceptions of the their work and the support that they require as well the clients perspectives and experiences of house rules and living conditions.

Negotiating Re-entry

In this category, I identified two areas research that require further investigation. First is the perception that clients are being screened out of the housing placement process. Second is the use of "de-housing". Participants in this study used the term to describe taking a client away from their accommodation. How long the client would be removed as a "consequence" of their situation varied; sometimes it was for a longer period than merely taking a client out of their residence for coffee while they calmed down; removal could be for an unspecified longer period. This practice, perceived or actual, requires further investigation, by examining this formal or informal policy used to control or manage the behaviour of clients that is judged as unacceptable. This practice is not consistent with housing HF philosophy.

Conclusion

The ACT teams work to reconcile the variance between the clients capabilities and characteristics and the conditions the client has to meet to remain housed. The participants identified the application of MI and HR principles as underpinning their practice however there were factors that made it challenging for the team fully apply these principles. The variance the teams work to reconcile can be widened or narrowed by conditions, factors, system-level issues, and their interaction. This study covered many broad interrelated topics and further research using a situational analysis approach would enable deeper analysis of the complexities that influence the team's work their provision of support to client to maintain housing. The contribution that this study makes to the existing knowledge and work that is being done in this region is that HF is not implemented in some contexts and the work of ACT is not consistent with HF. There are many factors that contribute to the cycle of homelessness within population of clients supported by the ACT team including a lack of affordable housing. The ACT team are providing the community infrastructure and support to their clients who have severe mental illness and do not consistently or readily engage with mental health services. This leaves open the questions of how ACT fits with HF in the regional context and how is housing first being implemented as program, policy and a philosophy?

References

Ahern, J., Stubes, J., & Galea, S. (2007). Stigma, discrimination and the health of illicit drug users. *Drug and Alcohol Dependence, 88*(2–3), 188–196.

Ackerson, J., Karoll. R. B. (2005). Evaluation of an Assertive Community Treatment Harm Reduction Program: Implementation issues. *Best Practices in Mental Health 1*(2) 34-49.

Alfred, C. A., Burns, B. J., & Phillips, S. D. (2005). The assertive community treatment team as a complex dynamic system of care. *Administration and Policy in Mental Health, 32*(3), 211–220.

Allen, G. (2003). *A critique of using grounded theory as a research method.* Department of Information Systems and Computer Applications, Portsmouth University, UK. Retrieved from http://www.ejbrm.com

Allen, M. (2003). Waking Rip Van Winkle: Why developments in the last 20 years should teach the mental health system not to use housing as a tool of coercion *Behavioral Sciences and the Law, 21*, 503–521.

American Psychiatric Association (2005). APA Gold American Psychiatric Association Award 2005: Providing housing first and recovery services for homeless adults with severe mental illness. *Psychiatric Services 2005* (1303–1304). doi: 10.1176/appi.ps.56.10

Atkey, J., & Siggner, R. (2008). *Still left behind: A comparison of living costs and income assistance in BC*. Social Planning and Research Council of British Columbia.

BC Ministry of Housing and Social Development (2008). BC employment and assistance rate tables. Retrieved from http://www.eia.gov.bc.ca/mhr/ia.htm

BC Ministry of Housing and Social Development. (2009). *Putting housing first: Progress and achievements on British Columbia's provincial housing strategy 2006–2008.*

Retrieved from http:/www.housingmattersbc.ca/docs/housingmatters_Progress.pdf

Bond, G. R., Drake, R. E., Mueser, K. T., & Latimer, E. (2001). Assertive community treatment for people with severe mental illness: Critical ingredients and impact on patients. *Disease Management Health Outcomes, 93*, 142–157.

Bond, G. R., McGrew, J. H., & Fekete, D. M. (1995). Assertive outreach for frequent users of psychiatric hospitals: A meta-analysis. *Journal of Mental Health Administration, 22*, 4–16.

Bond, G. R., Witheridge, T. F., Dincin, J., Wasmer, D., Webb, J., & De Graaf-Kaser, R. (1990). Assertive community treatment for frequent users of psychiatric hospitals in a large city: A controlled study. *American Journal of Community Psychology, 18*, 865–891.

Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Englewood Cliffs, NJ: Prentice-Hall.

Borland, A., McRae, J. & Lycan, C. (1989). Outcomes of five years of continuous intensive case management. *Hospital & Community Psychiatry, 40*, 369–376.

Bush, C. T., Langford, M. W., Rosen, P., & Gott, W. (1990). Operation outreach: Intensive case management for severely psychiatrically disabled adults. *Hospital & Community Psychiatry, 41*, 647–649.

Burns, B. J., & Santos, A. B. (1995). Assertive community treatment: An update of randomized trials. *Psychiatric Services, 46*, 669–675.

Burns, T., & Firn, M. (2002). *Assertive outreach in mental health: A manual for practitioners*. New York: Oxford University Press.

Canadian Mortgage and Housing Corporation. (2008, Spring). Rental market statistics. Ottawa: CMHC.

Canadian Homelessness Research Network. (2012). *Canadian definition of homelessness*.

Retrieved from http://www.homelesshub.ca/ResourceFiles/ 06122012CHRNhomelessdefinition.pdf

Canadian Medical Association. (2008). *8th annual national report card on health care*. Retrieved from http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Annual_Meeting/2008/GC_Bulletin/National_Report_Card_EN.pdf

Chan, C. (2010). Promises, promises: How many kept? Government: From social housing to a new urgent-care centre, action is being taken. *The Province*. Newspaper Division of Canwest. Retrieved from http://www.theprovince.com/news/Promises+promises+many+kept/2466526/story.html

Chudnovsky, D. (2008). *Finding our way home*. Official Report of Debates of the Legislative Assembly (Hansard), Monday, May 12, 2008, Morning Sitting. *33*, 1, 12247.

Cohen J.1993 Achieving a reduction in drug-related harm through education. In Heather N., Wodak A., Nadelmann E., O'Hare P. (Eds.), *Psychoactive drugs and harm reduction: From faith to science* (pp. 65–76). London: Whurr

Coldwell, C. M., & Bender, W. S. (2007). The effectiveness of assertive community treatment for homeless populations with severe mental illness: A meta-analysis. *American Journal of Psychiatry, 164*(3), 393–399.

Condon, M., & Newton. R. (2007). *In the proper hands: Research on homelessness and affordable housing*. Social Planning and Research Council of BC (SPARC BC).

Conrad, P. & Schneider, J. W. (1992). *Deviance and Medicalization: From Badness to Sickness.* Philadelphia, PA: Temple University Press.

Corbin, J. M., & Strauss, A. L. (2008). *Basics of qualitative research* (3rd ed.). Thousands Oaks California: Sage Publications.

Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice;* 9:35–42

Cosden, M., Ellens, J., Schnell, J., Yamini-Diouf, Y., & Wolfe, M. (2003). Evaluation of a mental health treatment court with assertive community treatment. *Behavioral Sciences & The Law*, *21*(4), 415-427.

Coursey, R. D., Curtis, L., Marsh, D. T., Campbell, J., Harding, C., Spaniol, L et al., (2000). Competencies for direct service staff members who work with adults with severe mental illnesses in outpatient public mental health/managed care systems. *Psychiatric Rehabilitation Journal, 23*(4), 370–377, 392.

Csiernik, R., Forchuk, C., Speechley, M., & Ward-Griffin, C. (2007). De “myth”ifying mental health—Findings from a Community Research Alliance (CURA) *Critical Social Work,* 8(1), [page nos.]

D’Amore, J., Hung, O., Chiang, W., & Goldfrank, L. (2001). The epidemiology of the homeless population and its impact on an urban emergency department. *Academic Emergency Medicine, 8*(11), 1051–1055.

Dates, B., Young, M. S., Bennett-Clark, F., Broner, N., Neumiller, S., Dejon, F., . . . Richards, S. (2009). Assertive community treatment fidelity in programs serving persons who are homeless with co-occurring mental and addictive disorders. *Journal of Dual Diagnosis, 5*(3–4), 264–286.

Dey I (1999) Grounding Grounded Theory Guidelines for Qualitative Inquiry, San Diego: Academic Press.

Dickson-Gomez J, Convey M, Hilario H, Corbett AM, Weeks, M: Unofficial policy:

Access to housing, housing information and social services among homeless drug users in Hartford. *Connecticut Substance Abuse Treatment Prevention Policy* 2:8. Retrieved from http://www.substanceabusepolicy.com/content/2/1/8.

Drake, R., Essock, S., Shaner, A., Carey, K., Minkoff, K., Kola, L.,…Rickards. L. et al. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services, 52*(4), 469–476.

Drake, R. E., Mueser, K. T., Torrey, W. C., Miller, A. L., Lehman A. F., Bond, G. R., & Leff, H. S. (2000). Evidence-based treatment of schizophrenia. *Current Psychiatry Reports, 2*, 393–397.

Drake, R. E., Meuser, K. T., Brunette, M. (2007). Management of persons with co-occurring severe mental illness and substance use disorder: program implications. *World Psychiatry,* 6(3), 131-138.

Drake R. E., O'Neal, E. L., Wallach, M. A (2008). A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental and substance use disorders. *Journal of Substance Abuse Treatment*, *34*, 123–138.

Drake, R. E., Osher, F. C., & Wallach, M. A. (1991, November). Homelessness and dual diagnosis. *American Psychologist, 46*(11), 1150.

Drake, R. E., Wallach, M. A., & McGovern, M. P. (2005). Future directions in preventing relapse to substance abuse among clients with severe mental illnesses. *Psychiatric Services, 56*(10). Retrieved from http://ps.psychiatryonline.org/article.aspx?articleid=90632

Drake, R. E., Wallach, M. A., Teague, G. B., Freeman, D. H., Paskus, T. S., & Clark, T. A. (1991) . Housing instability and homelessness among rural schizophrenic patients.

American Journal of Psychiatry, 48(3), 330–336.

Eberle, M., Kraus, G., & Serge, L. (2009). *Results of the pilot study to estimate the size of the hidden homeless population in Metro Vancouver*. Mustel Research Group, Market POWER Research Inc.

Echenberg, H., & Jensen, H. (2008). *Defining and enumerating homelessness in Canada*. Social Affairs Division of Parliamentary Information and Research Service. Retrieved from http://www.parl.gc.ca/Content/LOP/ResearchPublications/prb0830-e.pdf

Essock, S. M., Mueser, K. T., Drake, R. E., Covell, N. H., McHugo, G. J., Frisman, L. K., & Swain, K. (2006). Comparison of ACT and standard case management for delivering integrated treatment for co-occurring disorders. *Psychiatric Services*, *57*, 185–196.

Fazel, S., Khosla, V., Doll, H., & Geddes, J. (2008). Prevalence of mental disorders among the homeless in Western countries: Systematic review and meta-regression analysis. *PLOS Medicine, 5*(12), 1670–1681. Retrieved from http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.0050225

Fletcher, T. D., Cunningham, J. L., Calsyn, R. J., Morse, G. A., & Klinkenberg, W. D. (2008). Evaluation of treatment programs for dual-disorder individuals: modeling longitudinal and mediation effects. *Administrative Policy Mental Health*, *35*, 319–336.

Folsom, D.,Jeste, V. (2002) Schizophrenia in homeless persons: a systematic review of the literature. *Acta Psychiatrica Scandanavia* 105 (6) 404-413

Forchuk, C., MacClure, S. K., Van Beers, M., Smith, C., Csiernik, R., Hoch, J., & Jensen, E. (2008). Developing and testing an intervention to prevent homelessness among individuals discharged from psychiatric wards to shelters and 'no fixed address'. *Journal of Psychiatric and Mental Health Nursing, 15*, 569–575.

Frankish, C. J., Hwang, S. W., & Quantz, D. (2005). Homelessness and health in Canada: Research lessons and priorities. *Canadian Journal of Public Health,96* (Supplement 2).

Fries, P. H., Rosen, M. I. (2011). The efficacy of Assertive Community Treatment to treat substance use. *Journal of the American Psychiatric Nurses Association 17*(1), 45–50. doi:10.1177/1078390310393509

Gaetz, S (2010). The struggle to end homelessness in Canada: How we created the crisis, and how we can end it, *The Open Health Services and Policy Journal*, *3*, 21-26.

Gaetz, S., Scott, F., & Gulliver, T. (2013). A framework for Housing First in Canada supporting communities to end homelessness. Toronto: *Canadian Homelessness Research Network Press*. Retrieved from http://www.homelesshub.ca/ResourceFiles/Documents/HFCanada-Framework.pdf

Garland, O., Harrison, E., & Schwartz, C. (2007*). Treating concurrent substance use and mental health disorders in children and youth: A research report prepared for the Child and Youth Policy Branch.* Vancouver, BC: Simon Fraser University Press.

George, L., Durbin, J., & Koegl, C. J. (2009). System-wide implementation of ACT in Ontario: An ongoing improvement effort. *Journal of Behaviour and Health Science Services, 36*(3), 309–319.

Gilmer, T. P., Manning, W. G., & Ettner, S. L. (2009). The cost analysis of San Diego County's REACH program for homeless persons. *Psychiatric Services*, *60*(4). Retrieved from ps.psychiatricservices online.org

Girard, M.C. (2006). Determining the extent of the problem: The value and challenges of enumeration. *Canadian Review of Social Policy, 58*, 104.

Glaser, B. (1978). *Theoretical sensitivity*. San Francisco, CA: Sociology Press.

Glaser, B. (1992). *Basics of grounded theory analysis*. Mill Valley, CA: Sociology Press.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* New York: Aldine de Gruyter.

Goldner, E. M., Greaves, L., Hanncock, T. M., Kendall, P., Marsh, D., Poole, N., . . . Somers, J. (2004). Every door is the right door: a British Columbia planning. Retrieved from http://www.health.gov.bc.ca/library/publications/ year/2004/framework_for_substance_use_and_addiction.pdf

Goering, P., Tolomiczenko, G., Sheldon, T., Boydell, K., & Wasylenki, D. (2002). Characteristics of persons who are homeless for the first time. *Psychiatric Services, 53*, 1472–1474.

Greenwood, R. M., Schaefer-McDaniel, N. J., Winkel, G., & Tsemberis, S. J. (2005). Decreasing psychiatric symptoms by increasing choice in services for adults with histories of homelessness. *American Journal of Community Psychology, 36*(3), 223–238.

Gulcur, L., Stefanic, A., Shinn, M., Tsemberis, S., & Fischer, S. N. (2003). Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in the Continuum of Care and Housing First programmes. *Journal of Community & Applied Social Psychology*, *13,* 171–186.

Handmaker, N., Packard, M. & Conforti, K. (2002). Motivational interviewing in thetreatment of dual disorders. In W.R. Miller & S. Rollnick (Eds.), *Motivational Interviewing: Preparing People for Change* (2nd ed.), pp. 363-376. New York: Guilford Press.

Hunt, N. (2003) Forward Thinking on Drugs: A review of the evidence-base for harm reduction approaches to drug use retrieved from http://www.ihra.net/files/2010/05/31/HIVTop50Documents11.pdf

Hunter, J. (2009, February 16). Homeless take center stage in BC throne speech. *Globe and Mail*. Retrieved from http://v1.theglobeandmail.com/servlet/story / RTGAM.20090216.wbcthrone0216/BNStory/politics/

Hwang, S.W. (2001, January). Homelessness and health. *Canadian Medical Association Journal, 164*(2), 229–233.

International Harm Reduction Association (2010). *What is harm reduction? A position statement from the International Harm Reduction Association*. London, UK: International Harm Reduction Association.

Johnsen,S.,Teixeira, L, (2010) Staircases and Elevators " Housing First and Other Housing Models for Homeless People Living with Complex Support Needs. Retrieved from http://www.crisis.org.uk/data/files/publications/Housing%20Models%20Report.pdf

Johnson, G., & Chamberlain, C. (2011, Autumn). Are the homeless mentally ill? *Australian Journal of Social Issues, 46*(1).

Khoury, L., Tang, Y. L., Bradley, B., Cubells, J. F., & Ressler, K. J. (2010). Substance use, childhood traumatic experience, and Posttraumatic Stress Disorder in an urban civilian population. *Depression and Anxiety, 27*(12), 1077–1086.

Kirby, M. J. L., & Keon, W. J. (2006). *Out of the shadows at last: Transforming mental health, mental illness and addiction services in Canada.* Ottawa: Standing Senate Committee on Social Affairs, Science and Technology. Retrieved from www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/

soci-e/rep-e/rep02may06-e.htm

Klein, S., Cohen, M. G., Garner, T., Ivanova, I., Lee, M., Wallace, B., & Young, M. (2008). *A poverty reduction plan for BC.* Retrieved from http://www.policyalternatives.ca/sites/default/files/uploads/ publications/ BC%20Office/2011/07/ccpa_bc_poverty_reduction_full.pdf

Klein, S., & Pulkingham, J. (2008). Living on welfare in BC: Experiences of longer-term “Expected to Work” recipients. Vancouver: CCPA.

Kloos, B., Zimmerman, S. O., Scrimenti, K., & Crusto, C. (2002). Landlords as partners for promoting success in supported housing: “It takes more than a lease and a key.” *Psychiatric Rehabilitation Journal, 25*(3), 235–244.

Kraus, D., Serge, L., & Goldberg, M. (2006). Housing and services for people with substance use and mental health issues. The Social Planning and Research Council of BC.

Kreindler, S. A., & Coodin, S. (2010). Housing histories of assertive community treatment clients: Program impacts and factors associated with residential stability. *Canadian Journal of Psychiatry, 55*(3).

Krupa, T., Eastabrook, S., Hern, L., Lee, D., North, R., Percy, K., . . . Wing, G. (2005). How do people who receive assertive community treatment experience this service? *Psychiatric Rehabilitation Journal, 29*(1), 18–24.

Kyle, T., Dunn, J.R. (2008) Effects of Housing Circumstances on health, quality of life, and care use for people with severe mental illness: A review. *Health and Social Care in Community* 16 1-15.

Lenton, S., Single, E. (1998). The definition of harm reduction *Drug and Alcohol Review* 17 2 213-220

Lehman, A. F., Kernan, E., DeForge, B. R., & Dixon, L. (1995). Effects of homelessness on the quality of life of persons with severe mental illness. Psychiatric Services, 46(9), 922–926.

Lingard, J., Albert, M., & Levinson. (2008). Grounded theory, mixed methods, and action research. *British Medical Journal, 337*, 459–461.

Lipton, F. R., Siegel, C., Hannigan, A., Samuels, J., & Baker, S. (2000). Tenure in supportive housing for homeless persons with severe mental illness. *Psychiatric Services, 51*(4).

Lyon-Callo, V. (2000).Medicalizing homelessness: The productions of self-blame and self governing within homeless shelters. *Medical Anthropology Quarterly*, 14 3 p3298-345.

MacDonald, M. (2001). Finding a critical perspective in grounded theory. In R. S. Schreiber & P. N. Stern (Eds.), *Understanding grounded theory in nursing*. New York: Springer Publishing Company.

MacDonald, M., & Schreiber, R. (2001). Constructing and deconstructing: Grounded theory in a postmodern world. In R. S. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. 35–54). New York: Springer.

Manthey , T.J., Knolwes. B., Asher, D., Wahab, S. (2011) Strengths based motivational interviewing *Advances in Social Work* 12 (2) 126-151.

Marshall, M. & Lockwood, A. (1998). Assertive community treatment for people with severe mental disorders (Review). The Cochrane Library 2008, issue 4.

Martino, S., Carroll, K.M., Kostas, D., Perkins, J.,Rounsaville, B.J. (2002). Dual diagnosis motivational interviewing: A modification of motivational interviewing for substance abusing patients with psychiatric disorders.

Journal of Substance Abuse Treatment. 23 297-308.

Mate, Gabor. (2008). In the realm of hungry ghosts. Close encounters with addiction. Toronto: Random House

Matejkowski, J., & Draine, J. (2009). Investigating the impact of Housing First on ACT fidelity. *Community Mental Health Journal, 45*, 6–11.

Mills.J., Bonner, A., Francis, K. (2006) The development of constructivist grounded theory *International Journal of Qualitative Methods* 5 (1) 25-35

McGrew, J., & Bond, G. (1995), The association between program characteristics and service delivery in Assertive Community Treatment. *Administration and Policy in Mental Health, 25*(2), 175-179.

McGrew, J., Bond, G., Dietzen, L., & Slayers, M. (1994). Measuring the fidelity of implementation of a mental health program model. *Journal of Consulting and Clinical Psychology, 62*(3), 670–676.

McHugo, G. J., Drake, R. E., Teague, G. B., & Xie, H. (1999). Fidelity to assertive community treatment and client outcomes in the New Hampshire dual disorders study. *Psychiatric Services, 50*, 818–824.

Meisler, N., Blankertz, L., Santos, A. B., & McKay, C. (1997). Impact of assertive community treatment on homeless persons with co-occurring severe psychiatric and substance use disorders. *Community Mental Health Journal, 33*, 113–122.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford Press.

Ministry of Health (2013). *Factsheet: Mental health and substance use care in British Columbia.* Retrieved from http://www.newsroom.gov.bc.ca/ministries/health/factsheets/factsheet-mental-health-and-substance-use-care-in-british-columbia.html

Morse, J. M. (2001). Situating grounded theory within qualitative inquiry. In R. S. Schreiber & P. N. Stern (Eds.), *Understanding grounded theory in nursing*. New York: Springer Publishing Company.

Nelson, G., Aubry, T., & Lafrance, A. (2007). A review of the literature on the effectiveness of housing and support, assertive community treatment and intensive case management interventions for people with mental illness who have been homeless. *American Journal of Orthopsychiatry, 77*(3), 350–361.

Nelson G., Rae, J., Townley, G., Goering, P., McNaughton, E., Piat, M., . . . Tsemberis, S. (2013). Implementation and fidelity evaluation of the Mental Health Commission of Canada's At Home/Chez Soi project. *Cross Site Report*. Retrieved from http://www.mentalhealthcommission.ca/English/node/13611

Neumiller, S., Bennnet-Clark, F., Young. M. S., Bates, B., Broner, N., Leddy, J., & Kendall. D. (2009). Implementing assertive community treatment in diverse settings for people who are homeless with co-occurring mental and addictive disorders: A series of case studies. *Journal of Dual Diagnosis*, *5*(3–4), 239–263.

Padgett, D., Gulcur, L., & Tsemberis, S. (2006). Housing First services for people who are homeless with co-occurring serious mental illness and substance abuse. *Research on Social Work Practice, 16*, 74–83.

Padgett, D.K., Stanhope, V., Stefanic A (2009). Substance use outcomes among homeless clients with serious mental illness: comparing Housing First with Treatment First programs. Community *Mental Health journal* 27 (2) 227-232.

Patterson, M. (2007). Faces of homelessness across BC. Visions BC's *Mental Health and*

Addictions Journal, 4(1), 7–8.

Patterson, M., Somers, J. M., McIntosh, K., Shiell, A., & Frankish, C. J. (2008). *Housing and support for adults with severe addictions and/or mental illness in British Columbia.* Burnaby, BC: Centre for Applied Research in Mental Health and Addiction, Faculty of Health Sciences, Simon Fraser University.

Pauly, B., Cross, G., Vallance, K., Wynn-Williams, A., & Stiles, (2013). *Facing homelessness—2012/13 report on housing & supports.* Retrieved from http://www.homelesshub.ca/ ResourceFiles/ GVCEH_ReportHousingSupports_FINAL.pdf

Pearson, C., Montgomery, A. E., & Locke, G. (2009). Housing stability amongst homeless individuals with serious mental illness participating in Housing First programs. *Journal of Community Psychology, 37* (3), 404–417.

Pearson, C., Montgomery, A. E., Locke, G. Burrows, R (2007). The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness Washington DC, Department of Housing and Urban Development.

Perlman, J., Parvensky, J. (2006). Denver Housing First Collaborative: Cost Benefit Analysis and Program Outcomes Report. Denver: Colorado Coalition for the Homeless.

Perron, E,B., Eitzman, A, Gillespie, F.D. Pollio, D (2008) Modeling the mental health effects of victimization among homeless persons. *Social Science and Medicine67* 1475-1479.

Phillips, S. D., Burns, B. J., Edgar, E. R., Mueser, K. T., Linkins, K. W., Rosenheck, R. A., & McDonel Herr, E. C. (2001). Moving assertive community treatment into standard practice. *Psychiatric Services, 52*, 771–779.

Pleace, N., & Bretherton, J. (2012). *Will paradigm drift stop Housing First from ending homelessness? Categorising and critically assessing the Housing First movement from a social policy perspective.* Retrieved from http://www.york.ac.uk/media/chp/documents/2006/NPJB-EASP-SPA-2012.pdf

Quinlaven, R.; Hough, R.; Crowell, A.; Beach, C; Hofstetter, R.; and Kenworthy, K. Service utilization and costs of care for severely mentally ill clients in an intensive case management program. *Psychiatric Services,* 46:365-371, 1995.

Ranz,, M. J., & Mancini, D. A. (2008) Psychiatrists' reports of their own recovery-oriented practices. *Psychiatric Services, 59*(1), 100–104.

Raine, L., & Marcellin, T. (2007). What Housing First means for people. Streets to Homes Post-Occupancy Research Report. Toronto Shelter, Support and Housing Administration. Retrieved from http://www.toronto.ca/housing/pdf/results07postocc.pdf

Rapp, R. C. (2006). Strengths-based case management: Enhancing treatment for persons with substance abuse problems. In D. Saleebey (Ed.), *The strengths perspective in social work practice* (4th ed., pp. 128–147). Boston: Pearson Education, Inc.

Ridgway, P., Zipple, A.M. (1990) The paradigm shift in residential services: From the linear continuum to supported housing approaches Psychosocial Rehabilitation journal 13(4), 11-31

Riley. D.O'Hare, P. (2000) Harm Reduction: History Definition, and Practice Harm In Inciardi J.A and Harrison L.D. Harm Reduction National and International Perspectives Sage Publications London United Kingdom.

Room, R. (2005). Stigma, social inequality and alcohol and drug use. *Drug and Alcohol Review*, *24*, 143–155.

Rosenheck, R., Neale, M., Leaf, P., Milstein, R., & Frisman, L. (1995). Multisite experimental cost study of intensive psychiatric community care. *Schizophrenia Bulletin, 21*(1), 129–140.

Shapcott, M. (2007). The blueprint to end homelessness in Toronto. Toronto, ON: The Wellesley Institute.

Schneider, R. D., Bloom, H., & Heerema, M. (2007) Mental health courts decriminalizing the mentally ill. Toronto: Irwin Law.

Schreiber, R. S. (2001). The "how to" of grounded theory. In R. S. Schreiber & P. N. Stern (Eds.), *Understanding grounded theory in nursing*. New York: Springer Publishing Company.

Shaw, M. (2004). Housing and public health. *Annual Review of Public Health, 25*, 397–418.

Shaw, M., Dorling, D. & Davey Smith, G. (2006). Poverty, social exclusion, and minorities. In M. Marmot & R. G. Wilkinson (Eds.), *Social determinants of health*. Oxford: University Press.

Speziale, H. J., & Carpenter, D. R. (2007). *Qualitative research in nursing: Advancing the humanistic imperative*. Philadelphia: Lippincott Williams & Wilkins.

Stafford, M. & McCarthy, M. (2006). Neighborhoods, housing, and health. In M. Marmot & R. G. Wilkinson (Eds.), *Social determinants of health* (pp.132-145). Oxford: University Press.

Statistics Canada (2012). *Low income cut-offs.* Retrieved from http://www.statcan.gc.ca/pub/75f0002m/2012002/lico-sfr-eng.htm

Stanhope, V., Marcus, S., Solomon P (2009) The impact of coercion on services from perspective of mental health care consumers with co-ocurring disorder

Psychiatric Services 60 183-188.

Stefanic, A. & Tsemberis, S. (2007) Housing first for long-tem shelter dwellers with psychiatric disabilities in a suburban county: A four-year study of housing access and retention. *Journal of Primary Prevention,* 28(3-4), 265–279.

Stein, L. I., & Test, M. A. (1980). An alternative to mental health treatment. I: Conceptual model, treatment program, and clinical evaluation. *Archives of General Psychiatry, 37*, 392–397.

Steinberg M, Ziedonis D, Krejci J, Brandon T. (2004). Motivational interviewing with personalized feedback: A brief intervention for motivating smokers with schizophrenia to seek treatment for tobacco dependence. *Journal of Consulting and Clinical Psychology.* 72(4):723-728.

Stern, P. N., & Covan, E. K. (2001). Early grounded theory, its process and products. In R. S. Schreiber & P. N. Stern (Eds.), *Understanding grounded theory in nursing*. New York: Springer Publishing Company.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage.

Strike, C. J., Myers. T., & Millson, P. (2004). Finding a place for needle exchange programs. *Critical Public Health, 14*(3), 261-275.

Sullivan G, Burnam, A., Koegal, P., (2000), Pathways to homelessness among mentally ill. *Social Psychiatry and Psychiatric Epidemiology*. 35 444-450.

Takahashi, L. M. (1997). The socio-spatial stigmatization of homelessness and HIV/AIDS: Toward an explanation of the NIMBY syndrome. Social Science & Medicine, 45(6), 903-914.

Teague, G. B., Bond, G. R., & Drake, R. E. (1998). Program fidelity in assertive community treatment: Development and use of a measure. *American Journal of Orthopsychiatry, 68*, 216–232.

Teague, G. B., Drake, R. E., &, Akerso T. H. (1995). Evaluating use of continuous treatment teams for persons with mental illness and substance abuse. *Psychiatric Services, 46*, 689–695.

Test, M. A. (1992). Training in community living. In R. P. Lieberman (Ed.), *Handbook of psychiatric rehabilitation*. New York: Macmillan.

Tsai, J., Mares, A. S., & Rosenheck, R. A. (2010). A multi-site comparison of supported housing for chronically homeless adults: "Housing first" versus "residential treatment first." *Psychological Services, 7*(4), 219–232.

Tsemberis, S. (1999). From streets to homes: An innovative approach to supported housing for homeless adults with psychiatric disabilities. *Journal of Community Psychology, 27*, 225–241.

Tsemberis, S. (2010). *Housing first: The pathways model to end homelessness for people with mental illness and addiction*. Dartmouth: Hazelden.

Tsemberis, S. (2010). Housing first: Ending homelessness, promoting recovery and reducing costs. In E. I. Gould & B. O'Flaherty (Eds.), *How to house the homeless*. New York: Russell Sage Foundation.

Tsemberis, S., & Elfenbein, C. (1999). A perspective on voluntary and involuntary outreach services for the homeless mentally ill. *New Directions for Mental Health Services, 82*, 9–19.

Tsemebris S., Eisenberg R.F., (2000) Pathways to housing: supported housing for street-dwelling homeless individuals with psychiatric disabilities *Journal of Psychiatric services*

Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing First, consumer choice, and harm reduction for individuals who are homeless with dual diagnosis: A 24-month follow up. *American Journal of Public Health, 94*(4), 651– 656.

Van der Leer, G., Musgrave, I., Somers, J., Samara, J., & Queree, M. (2008). *British Columbia standards for Assertive Community (ACT) treatment teams.* British Columbia Ministry of Health Services. Retrieved from http://www.health.gov.bc.ca/librarypublications/year/ 2008/BC_Standards_for_ACT_Teams.pdf

Walker, D. (2010, February 18). Outreach workers face rent challenge: Nanaimo team fighting homelessness has less access to funding than Victoria counterparts. *Daily News*.

Wallace, B., Klein, S., & Reitsma-Street, M. (2006). *Denied assistance: Closing the front door on welfare in BC*. Vancouver: CCPA and the Vancouver Island Public Interest Research Group. Retrieved from http://www.policyalternatives.ca/sites/default/files/uploads/ publications/ BC_Office_Pubs/bc_2006/denied_assistance.pdf

Watts, J., & Priebe, S. (2002). A phenomenological account of users' experiences of Assertive Community Treatment. *Bioethics* 16(5).

Wenzel, S. L., Leake, B. D., & Gelberg, L. (2000). Health of homeless women with recent experience of rape. *Journal of General Internal Medicine,*15(4), 265–268.

Williams, J. (2008). Symbolic interactionism. In L. Given (Ed.), *The SAGE encyclopedia of qualitative research methods* (pp. 849–854). Thousand Oaks, CA: Sage Publications.

Williams, K., Kukla, M., Bond, R. G., McKasson, M., & Salyers, M. P. (2009). Can a nurse practitioner serve in a prescriber role on an assertive community treatment team? *American Journal of Psychiatric Rehabilitation, 12*(3), 205– 210.

Willse, C. (2010). Neo-liberal Biopolitics and the Invention of Chronic Homelessness. *Economy and Society, 39*(2), 155–184.

Wong, L., Poulin S. R., Lee, S., Davis, M. R., & Hadley, T. R. (2008). Tracking residential outcomes of supported independent living programs for persons with serious mental illness. *Evaluation and Program Planning, 31*(4), 416-426.

Ziedonis, D. M., (2004) Integrated Treatment of Co-Occurring Mental Illness and Addiction: Clinical Intervention, Program, and System Perspectives. Retrieved from http://www.cnsspectrums.com/aspx/articledetail.aspx?articleid=544

Appendices

Appendix A

Recruitment Poster

DEPARTMENT OF NURSING UNIVERSITY OF VICTORIA BC

Supervisor Dr. Marjorie MacDonald UVIC School of Nursing e-mail [redacted]

PARTICIPANTS NEEDED FOR RESEARCH IN

SUPPORTING CLIENTS TO ATTAIN AND MAINTAIN HOUSING

I am looking for volunteers to take part in a research study to explore the issues and challenges encountered, in the complex and intense work, in supporting clients to attain and maintain housing. Your perspectives, experiences and insight into both the difficulties and the effective strategies are being sought. I am looking for:

Two participants from each of the following three ACT teams [Names of teams removed] to participate in two focus group discussions each of 2 hours duration; &

One member from each team to allow me to shadow them during a shift and to be interviewed during that time

For more information about this study, or to volunteer to participate please contact: Shona Lalonde phone number or E-Mail [redacted]

Appendix B

Participant Recruiting Email

This e-mail will be sent with the poster to the 3 Team Leaders, the Police Officer and, the Financial Aid worker who is working with the teams.

Dear (individuals name),

Please see the attached poster.

My name is Shona Lalonde. I am wondering if you are willing to allow me to interview you about your experiences as you work with the team(s) as they implement the housing first strategy and support clients to attain and maintain housing.

I respect that you are very busy but I am interested in your perspectives and experiences.

You are under no obligation to participate in this study.

Thank you for taking the time to read this request. Shona Lalonde RN BScN, Masters Student in Nursing

Phone number [redacted]

E-mail-[redacted]

Appendix C

Information Session For Team Members

Thank you for allowing me the opportunity to discuss this research study with you and to answer your questions about the study and participation in the study

Introduce self and background and interests in the research topic.

Clarification of my role as a student researcher (as I worked with one team as a practicum student in the past). Offer the opportunity to ask questions.

About the study

Explanation of the study, as per ethics proposal and the consent forms, including study objectives, benefits of participating in the study, inconvenience confidentiality, anonymity.

Refer to the poster and explain what participation will entail for one on one interviews, shadow shift, and being present to participate in the post team meeting discussion)

Offer opportunity to answer questions.

Permission to Attend a Team Meeting

I am seeking permission to attend a team meeting (with one of the three teams).

My purpose in attending the meeting is to be present when discussion take place about housing clients (for example, the day to day work done by team members in the area of supporting clients to attain housing and remain housed, discussions around housing placement, obtaining finances for clients to cover the rent)

I will not participate in the meeting, but will take notes.

At the end of the meeting I ask questions that arose for me during the teams discussions.

I would like to audio-tape both the questions and the answers. This is done to facilitate accurate transcription and analysis of the data.

Client names will not be used.

Seeking Consent

In order for me to present at the team meeting, team members who are present will all have to agree that I can attend.

In order for me for me to use the data gathered for the research study (during discussions, through note taking and audio- tapes) those present will have to sign a consent form.

By signing the consent for you will be participants in the study.

Review of consent form (consent form see appendix N).

The consent form will be left with team leaders.

The decision to participate in this study voluntary I encouraged you to discuss this amongst yourselves and let the team leader know if you want to participate in this study (discussion take place after I have left).

The team leader will inform if I can attend a meeting and specify which meeting. Consent forms will be left with your team leader.

Offer the opportunity to ask questions.

I will be available to a answer any questions via e-mail or phone once again refer to poster with contact details.

Thank you.

Appendix D[17]

Interview Discussion Topics Post Team Meeting

How does the whole team work together to support clients in housing? What challenges have you encounter when providing this support?

Discussion of a specific issue related to housing support that came up during the meeting (e.g., review of the suitability of a housing placement, risk of eviction, conflict within the living situation, change in mental health status, funding to cover rent).

---

[17] Not conducted

Appendix E

Focus Group Discussion Questions

ACT teams provide many services for severely mentally ill clients; tell me about the work you do on a daily basis when working with clients to attain housing and housing stability?

What type of support is needed to maintain clients in housing? How is the support provided?

What strategies have been successful when working with clients to attain or maintain housing? What hasn't worked and why?

When doing the literature review for this research study, I read two studies identifying that ACT team members often struggled to balance the need to work with clients to maintain their accommodation with providing treatment and working to set goals and to attain them: What is your experience? Does this influence the support or services that you provide or the day to day work that you do?

Appendix F

Interview Questions Shadow Shift Discussion

When doing the literature review for this research study, I read a number of studies that identified that the neighbourhood and environment as either positively or negatively affecting the clients mental health, well being as well and their housing stability. From your experience what are you thoughts about this?

What type of housing is available to clients in terms of level of: support with in the housing facility, wet or dry housing? In the field: Tell me about this facility (we are visiting) or housing situation

What challenges have you as a team member encountered when supporting clients in housing? How were the challenges or situations managed?

What was the outcome?

Appendix G

Interview with team leaders

How are decisions made about where to place clients in housing/what criteria is used? What are the housing options?

What is the availability of housing for this client population?

Have there been any client housing related issues that you have had to work through with the team members. If so what type of issues? How did the situation unfold?

What do you think have been the biggest successes in this initiative to house this client population? How does the team support clients in housing?

Appendix H

Interview with a Police Officers linked/working with the teams

What is your role when working with the teams?

When doing the literature review for this research study, I read a number of studies that identified that the neighbourhood and environment, in which as client is housed as either positively or negatively affecting the clients mental health and well being as well and their housing stability. From your experience what are you thoughts about this? Does the neighbourhood or environment, in which the client is housed influence the type of support that you provide to the team members? If so, how?

The Police Department report 2009 noted many success in terms of reduced police calls when severely mentally ill clients were housed and linked to the ACT teams:

What type of support do you think is needed to ensure clients remain housed?

Appendix J

Interview with the financial aid workers[18]

What is your role in working with the teams?

What finances are available to assist clients to attain housing and remain housed.

What challenges do you encounter when providing this support? How do you manage these challenges?

---

[18] This interview was not conducted

Appendix K

Consent for Focus Group Discussion

You are invited to participate in a study entitled: How do ACT (Assertive Community Treatment) teams and teams using the principles of ACT support clients to attain and maintain housing? This study is being conducted by Shona Lalonde RN BScN.

My name is Shona Lalonde I am a Masters Student in the Department of Nursing at the University of Victoria. You may contact me by phone or email if you have any questions about this research study.

[redacted] (Home) [redacted] (Cell) e-mail [redacted]

I am conducting this research to fulfill the requirements for the degree of Master of Nursing. My research is being conducted under the supervision of Dr. Marjorie MacDonald. You may contact my supervisor at [redacted] (office) or by email [redacted]

[redacted], a Ph.D. student at the University of Victoria, BC, will assist me to collect data during the focus group discussions by taking written notes and audio-recording the group discussion.

Purpose and Objectives of This Study

The purpose of this research study is to gain an understanding of the complex work members of ACT teams do to support clients to attain and retain housing. Not only is there a lack of affordable housing, but severely mentally ill and or addicted individuals encounter many barriers to attaining housing. There are numerous situations that can lead to housing instability (e.g., decompensation in the client's mental health and client behaviour). The capacity of team members to pre-empt or ameliorate the challenges that lead to housing instability will be explored. The successes and barriers that ACT team members have experienced in housing clients and the factors that contribute to success will be examined.

The services provided by team members that are specific to supporting a client's housing stability will be identified. The professional skills and strengths used by the multidisciplinary team will be explored. The participants' experiences and insights will guide this research study.

The Importance of This Research

The knowledge gained from this research study could possibly a) help define how team members can best supported in the work they do; and b) identify how clients can best be supported to attain housing stability. Identification of the challenges and issues the team members encounter could inform future actions from within the team, the health authority, and associated agencies. The identification of strategies to support clients in housing could lead to improved outcomes for clients. The results of this study, encompassing the unique perspective of the team members and their insights, will contribute to a larger a body of knowledge related to supporting the severely mentally ill and individuals who have problems with addictions in housing.

Participant Selection

You have been asked to participate in this study because you are a member of an ACT or an ACT-like team who works with clients who suffer from severe mental illness and / or addictions, who are homeless, or whose housing situation is unstable.

What is involved?

If you agree to voluntarily participate in this research study your participation will include spending 1.5 to 2 hours for each of two focus group discussions. A focus group in this case consist of 6 people who will be guided by the researcher through an in-depth discussion of their perceptions and experiences about the research topic. The focus group will be made up of study participants who are members of Victoria ACT teams; for example, mental health outreach workers, social workers, and nurses.

The focus group discussions will be audio taped to ensure accuracy of the interpretation and analysis of data. [redacted] a Ph.D. student, from the [redacted], will assist me to collect data during the focus group discussions by taking written notes and audio-recording the group discussion. To help focus the discussion and capture ideas, key points will be noted on flip chart paper. The audiotapes, notes of the focus group discussion, and the flip chart paper will be retained for analysis. The audiotaped discussions will be transcribed by either myself or a transcriptionist who is bound by a code of confidentiality. The transcriptionist's name is ___________________________________. The transcriptionist listens to the audiotapes and writes down what was said. This is done as an essential part of the data analysis process.

Ongoing Consent

Participants may be contacted (by myself, the researcher) after the focus group discussion to verify that the information collected during the discussion is accurately represented. Continued discussion with the researcher remains voluntary and confidential.

Inconvenience

Participation in this study may cause some inconvenience to you as it may cut into to your personal, family or work time. To facilitate your participation the focus group discussion will take place during regular work hours in a meeting room at the Pandora Street office. Out of respect for the participants' time, and to support a less formal atmosphere for discussion, refreshments and snacks will be provided.

Anonymity

As the focus group discussion is being held in the work place peers and staff may see you entering or leaving the focus group meeting room and may be aware that you are participating in the research study. It may be necessary for you to reschedule your workload therefore your peers and team leader could be aware of your participation. However, your anonymity will be maintained within the published research.

In the publication and dissemination of the research results reference will be made to BC ACT teams and will not identify the teams as [redacted] ACT teams. However readers who are familiar with the history of ACT in BC may identify this work as being based on the [redacted] ACT teams. The anonymity of the participants will be maintained throughout the study. Neither the participants' names or other identifying information will be included in published research or in the presentation of data. Information that could potentially identify an individual will be withheld. Participants' names will not be directly attached to any data (such as audio tape recordings, interview notes, memos, transcripts or data entered into the electronic data base).

Each participant will be given a unique identification code. All data will be labeled with the participant's identification code. A document linking the identification code to the participant will be stored in a locked filing cabinet and I, the principle investigator, am the only person who will have access to the filing cabinet and the document.

Portions of de-identified data will be shared with my master's thesis supervisory committee and members of the Grounded Theory Research Group as they will be guiding me through the data analysis process. One of the reasons for sharing the data analysis process is to ensure that I, as a researcher, derive my analysis from the data as opposed to my own preconceived ideas or bias.

Confidentiality

Due to the nature of the activity, a focus group discussion, the researcher cannot guarantee that confidentiality will be maintained. It is up to all participants, as members of the focus group, to maintain confidentiality outside the group. Participants are encouraged not to share information they wish to keep private, discuss topics, or divulge information that they are uncomfortable sharing with other members of the group. The focus group participants will be reminded at the beginning of each discussion that a) having signed the consent form they are agreeing to maintain confidentiality; and that b) the maintenance of confidentiality is a condition of participating in this study.

Risks

There are no known or anticipated risks to participating in this research. However your participation may be very stressful and the group discussion may cause some feelings of anxiety. Along with this consent form you will find information about counseling services. Please be aware that you do not have to discuss topics or divulge information that you are uncomfortable with. If you are feeling stressed or no longer wish to participate you can withdraw from the discussion at any time.

Compensation

No financial compensation will be provided.

Voluntary Participation

Your participation in this research must be completely voluntary. You may withdraw from the study at any time without any consequences or penalty, and can do so without explanation. If you withdraw from the study it may not be possible to remove data derived from your participation up to that time from the database.

Researcher's Relationship with Participants

There is no power over relationship between the researcher and the participant. The researcher does not have supervisory capacity over the participant.

Dissemination of Results

It is anticipated that the results of this study will be shared with others in the following ways:

- Presented to the participants prior to my defense.

- Published as a graduate thesis and available on line.
- Provided (in form of thesis) to the ACT teams and to the Health Authority.
- Presented in scholarly presentations, conferences, and meetings.
- Disseminated in journal articles.

The results of this research will not be used for commercial purposes.

Storage of Data

Once the data are recorded using an audio-recorder, the data will be transcribed by either myself or a qualified transcriptionist The transcribed data will be entered into a computer database. The computer will be password protected and will be off when not in use. The audio-tapes will be retained for interpretation, ongoing analysis and validation. All audio-tapes, along with paper records of data, will be kept locked in a filing cabinet at (my) the principal investigator's home.

A USB drive will be used to back up the study data. The USB drive will not be used in any other computer except for my laptop dedicated for use during the research study. I will be the only person with access to the computer.

Disposal of Data:

Following the publication of the thesis (anticipated January 2013/ Published 2014) all data from this study will be disposed of. All documents such as paper, index cards, and transcribed data will be shredded in a confidential shredder. Any data related to this study that is on a computer hard drive or USB stick will be deleted.

Contacts

If you have any questions or concerns about this research study please refer to the contact information at the beginning of the consent form. In addition, you may verify the ethical approval of this study, or raise any concerns by contacting the Human Research Ethics

Office at [redacted] (Phone number [redacted] or e-mail [redacted] or by contacting the Research Ethics Office phone number

Your signature below indicates that you understand the above conditions of participation; that you are not going to repeat or divulge information heard during the focus group discussions; and that you have had the opportunity to have your questions answered by the researcher.

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Participant Name (Please Print) _______

Participant Signature___

Date___

Witness Signature_____

Date___

Appendix L

Shadow Shift Consent

You are invited to participate in a study entitled How do ACT (Assertive Community Treatment) teams and teams using the principles of ACT support clients to attain and maintain housing? This study is being conducted by Shona Lalonde RN BScN.

My name is Shona Lalonde I am a Masters Student in the Department of Nursing at the University of Victoria. You may contact me by phone or email if you have any questions about this research study.

[redacted] (Home) [redacted] (Cell) ______ e-mailslalonde@uvic.ca

I am conducting this research to fulfill the requirements for the degree of Master of Nursing. My research is being conducted under the supervision of Dr. Marjorie MacDonald. You may contact my supervisor at [redacted] (office) or by e-mail [redacted]

[redacted] a Phd student at the University of Victoria, BC, will assist me to collect data during the focus group discussions by taking written notes and audio-recording the group discussion.

Purpose and Objectives of This Study

The purpose of this research study is to gain an understanding of the complex work members of ACT teams do to support clients to attain and retain housing. Not only is there a lack of affordable housing, but severely mentally ill and or addicted individuals encounter many barriers to attaining housing. There are numerous situations that can lead to housing instability (e.g., decompensation in the client's mental health and client behaviour). The capacity of team members to pre-empt or ameliorate the challenges that lead to housing instability will be explored. The successes and barriers that ACT team members have experienced in housing clients and the factors that contribute to success will be examined.

The services provided by team members that are specific to supporting a client's housing stability will be identified. The professional skills and strengths used by the multidisciplinary team will be explored. The participants' experiences and insights will guide this research study.

The Importance of This Research

The knowledge gained from this research study could possibly a) help define how team members can best supported in the work they do; and b) identify how clients can best be supported to attain housing stability. Identification of the challenges and issues the team members encounter could inform future actions from within the team, the health authority, and associated agencies. The identification of strategies to support clients in housing could lead to improved outcomes for clients. The results of this study, encompassing the unique perspective of the team members and their insights, will contribute to a larger a body of knowledge related to supporting the severely mentally ill and individuals who have problems with addictions in housing.

Participant Selection

You have been asked to participate in this study because you are a member of an ACT or an

ACT-like team who works with clients who suffer from severe mental illness and / or addictions, who are homeless, or whose housing situation is unstable.

What is involved

If you agree to voluntarily participate in this research study your participation will include spending 1.5 to 2 hours for each of two focus group discussions. A focus group in this case consist of 6 people who will be guided by the researcher through an in-depth discussion of their perceptions and experiences about the research topic. The focus group will be made up of study participants who are members of Victoria ACT teams; for example, mental health outreach workers, social workers, and nurses.

The focus group discussions will be audio taped to ensure accuracy of the interpretation and analysis of data. [redacted] a Ph.D. student, at the University of Victoria, BC, will assist me to collect data during the focus group discussions by taking written notes and audio-recording the group discussion. To help focus the discussion and capture ideas, key points will be noted on flip chart paper. The audiotapes, notes of the focus group discussion, and the flip chart paper will be retained for analysis. The audiotaped discussions will be transcribed by either myself or a transcriptionist who is bound by a code of confidentiality. The transcriptionist's name is___________________________________. The transcriptionist listens to the audiotapes and writes down what was said. This is done as an essential part of the data analysis process.

Ongoing Consent

Participants may be contacted (by myself, the researcher) after the focus group discussion to verify that the information collected during the discussion is accurately represented. Continued discussion with the researcher remains voluntary and confidential.

Inconvenience

Participation in this study may cause some inconvenience to you as it may cut into to your personal, family or work time. To facilitate your participation the focus group discussion will take place during regular work hours in a meeting room at the Pandora Street office. Out of respect for the participants time, and to support a less formal atmosphere for discussion, refreshments and snacks will be provided.

Anonymity

As the focus group discussion is being held in the work place peers and staff may see you entering or leaving the focus group meeting room and may be aware that you are participating in the research study. It may be necessary for you to reschedule your workload therefore your peers and team leader could be aware of your participation. However, your anonymity will be maintained within the published research.

In the publication and dissemination of the research results reference will be made to BC ACT teams and will not identify the teams as Victoria ACT teams. However readers who are familiar with the history of ACT in BC may identify this work as being based on the Victoria ACT teams. The anonymity of the participants will be maintained throughout the study.

Neither the participants' names or other identifying information will be included in published research or in the presentation of data. Information that could potentially identify an individual will be withheld. Participants' names will not be directly attached to any data (such as audio tape recordings, interview notes, memos, transcripts or data entered into the electronic data base).

Each participant will be given a unique identification code. All data will be labeled with the participant's identification code. A document linking the identification code to the participant will be stored in a locked filing cabinet and I, the principle investigator, am the only person who will have access to the filing cabinet and the document.

Portions of de-identified data will be shared with my master's thesis supervisory committee and members of the Grounded Theory Research Group as they will be guiding me through the data analysis process. One of the reasons for sharing the data analysis process is to ensure that I, as a researcher, derive my analysis from the data as opposed to my own preconceived ideas or bias.

Confidentiality

Due to the nature of the activity, a focus group discussion, the researcher cannot guarantee that confidentiality will be maintained. It is up to all participants, as members of the focus group, to maintain confidentiality outside the group. Participants are encouraged not to share information they wish to keep private, discuss topics, or divulge information that they are uncomfortable sharing with other members of the group. The focus group participants will be reminded at the beginning of each discussion that a) having signed the consent form they are agreeing to maintain confidentiality; and that b) the maintenance of confidentiality is a condition of participating in this study.

Risks

There are no known or anticipated risks to participating in this research. However your participation may be very stressful and the group discussion may cause some feelings of anxiety. Along with this consent form you will find information about counseling services.

Please be aware that you do not have to discuss topics or divulge information that you are uncomfortable with. If you are feeling stressed or no longer wish to participate you can withdraw from the discussion at any time.

Compensation

No financial compensation will be provided.

Voluntary Participation

Your participation in this research must be completely voluntary. You may withdraw from the study at any time without any consequences or penalty, and can do so without explanation. If you withdraw from the study it may not be possible to remove data derived from your participation up to that time from the database.

Researcher's Relationship with Participants

There is no power over relationship between the researcher and the participant. The researcher does not have supervisory capacity over the participant.

Dissemination of Results

It is anticipated that the results of this study will be shared with others in the following ways:

- Presented to the participants prior to my defense.
- Published as a graduate thesis and available on line.
- Provided (in form of thesis) to the ACT teams and to VIHA.
- Presented in scholarly presentations, conferences, and meetings.
- Disseminated in journal articles.

The results of this research will not be used for commercial purposes.

Storage of Data

Once the data are recorded using an audio-recorder, the data will be transcribed by either myself or a qualified transcriptionist. The transcribed data will be entered into a computer database. The computer will be password protected and will be off when not in use. The audiotapes will be retained for interpretation, ongoing analysis and validation. All audiotapes, along with paper records of data, will be kept locked in a filing cabinet at (my) the principal investigator's home.

A USB drive will be used to back up the study data. The USB drive will not be used in any other computer except for my laptop dedicated for use during the research study. I will be the only person with access to the computer.

Disposal of Data:

Following the publication of the thesis (anticipated January 2013) all data from this study will be disposed of. All documents such as paper, index cards, and transcribed data will be shredded in a confidential shredder. Any data related to this study that is on a computer hard drive or USB stick will be deleted.

Contacts

If you have any questions or concerns about this research study please refer to the contact information at the beginning of the consent form. In addition, you may verify the ethical approval of this study, or raise any concerns by contacting the Human Research Ethics Office at the [redacted]phone [redacted] or by contacting the Research Ethics Office [redacted]

Your signature below indicates that you understand the above conditions of participation; that you are not going to repeat or divulge information heard during the focus group discussions; and that you have had the opportunity to have your questions answered by the researcher.

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Participant Name (Please Print) _______

Participant Signature___

Date___

Witness Signature_____

Date___

Appendix M

One-on-One Interview Consent

You are invited to participate in a study entitled How do ACT (Assertive Community Treatment) teams and teams using the principles of ACT support clients to attain and maintain housing? This study is being conducted by Shona Lalonde RN BScN.

My name is Shona Lalonde. I am a Master's Student in the Department of Nursing at the University of Victoria. You may contact me by phone or email if you have any questions about this research study.

[redacted] (Home) [redacted] (Cell) e-mail [redacted]

I am required to conduct research as part of the requirements for the degree of Master of Nursing. My research is being conducted under the supervision of Dr. MacDonald. You may contact my supervisor at [redacted] (office) or by e-mail [redacted]

Purpose and Objectives of This Study

The purpose of this research study is to gain an understanding of the complex work members of ACT teams do to support clients to attain and retain housing. Not only is there a lack of affordable housing, but severely mentally ill and or addicted individuals encounter many barriers to attaining housing. There are numerous situations that can lead to housing instability (e.g., decompensation in the client's mental health and client behaviour). The capacity of team members to pre-empt or ameliorate the challenges that lead to housing instability will be explored. The successes and barriers that ACT team members have experienced in housing clients and the factors that contribute to success will be examined. The services provided by team members that are specific to supporting a client's housing stability will be identified. The professional skills and strengths used by the multidisciplinary team will be explored. The participants' experiences and insights will guide this research study.

The Importance of This Research

The knowledge gained from this research study could possibly a) help define how team members can best supported in the work they do; and b) identify how clients can best be supported to attain housing stability. Identification of the challenges and issues the team members encounter could inform future actions from within the team, the health authority, and associated agencies. The identification of strategies to support clients in housing could lead to improved outcomes for clients. The results of this study, encompassing the unique perspective of the team members and their insights, will contribute to a larger a body of knowledge related to supporting the severely mentally ill and individuals who have problems with addictions in housing.

Participant Selection

You have been asked to participate in this study as you are a member of, or work with members of an ACT (or ACT like team) who provide support to clients who suffer from severe mental illness and or addictions, who are homeless or whose housing situation is unstable.

What is involved

If you agree to voluntarily participate in this study your participation would include a 45-minute interview with me. I will audiotape the interview to ensure accuracy of the interpretation of your statements. The audio taped discussions will be transcribed by myself or a transcriptionist who is a professional and bound by a code of confidentiality. The transcriptionist's name is ____.

The transcriptionist will listen to the tape-recorded interview and will write out what has been said. This is done to help me, the researcher, with the data collection and analysis process.

Ongoing Consent

I, the researcher, may contact you, the participant, to clarify information and to verify my interpretation of the interview. Your continued discussion with the researcher remains voluntary and confidential.

Inconvenience

To minimize inconvenience and maintain anonymity the time and location of the interview will be chosen by (you) the participant.

Risks

There are no known or anticipated risks to participating in this study. However, your participation may be very stressful and cause some feelings of anxiety. If you feel tension or stress during our interview we can take a break then resume the discussion. You do not have to discuss topics or divulge information that you are uncomfortable with. If you are feeling stressed or no longer wish to participate you can withdraw from the discussion at any time.

Along with this consent form you will find information about counseling services.

Compensation

No financial compensation will be provided.

Voluntary Participation

Your participation in this research must be completely voluntary. You may withdraw from the study at any time without any consequences or penalty, and can do so without an explanation. If you withdraw from the study it may not be possible to remove data derived from your interview from the data base.

Researcher's Relationship with Participants

There is no power over relationship between the researcher and the participant. The researcher does not have supervisory capacity over the participant.

Confidentiality

I have had to approach your manager to seek permission to recruit you for this study. The manager will not know whether or not you have participated in the study, but the manager will be aware that you could have participated.

Anonymity

The anonymity of the participants will be maintained throughout the study and dissemination and publication of results. To maintain participant anonymity, neither the participants' names or other identifying information will be included in published research or in the presentation of data. Information that could potentially identify an individual will be withheld.

Reference will be made to BC ACT teams in the publication and dissemination of the research results. However, the research results will not identify the teams as [redacted] ACT teams. Readers who are familiar with the history of ACT in BC may, however, identify that this work was based on the [redacted] ACT teams.

The participants' name will not be directly attached to any data (such as audio tape recordings, interview notes, memos, transcripts, or into the electronic data base). Each participant will be given a unique identification code. All data will be labeled with the participant's identification code. A document linking the identification code to the participant will be stored in a locked filing cabinet and I, the principle investigator, am the only person who will have access to the filing cabinet and the document.

Portions of de-identified data will be shared with my thesis supervisor, my thesis supervisory committee members, and members of the Grounded Theory Research Group as they will be guiding me through the data analysis process. One of the reasons for sharing the data is to ensure that I, as a researcher, derive my analysis from the data as opposed to my own preconceived ideas or bias.

The results of this research will not be used for commercial purposes.

Dissemination of Results

It is anticipated that the results of this study will be shared with others in the following ways:

- Presented to the participants prior to my defense.
- Published as a graduate thesis and available on line.
- Provided (in form of thesis) to the ACT teams and to the health authority
- Presented at Scholarly presentations, conferences, and meetings.
- Disseminated in journal articles.

Storage of Data

Once the data are recorded using an audio-recorder, the data will be transcribed by either myself or a qualified transcriptionist. The transcribed data will be entered into an electronic database. As part of the analysis process, the transcribed data may also be transferred onto index cards

Neither the data entered into the database nor onto the index cards will contain identifying information. Each data base entry and or index card will be labeled with a participant number.

The audiotapes will be retained for interpretation and ongoing analysis and validation. All audiotapes will locked in a filing cabinet at (my) the principal investigator's home. A USB drive will be used to back up the study data. The USB drive will not be used in any other computer except for my laptop dedicated for use during the research study. The laptop will be password protected and will be off when not in use. I will be the only person with access to the computer.

Disposal of Data

Following the publication of the thesis (expected January 2013 now January 2014), all data from this study will be disposed of. All documents such as paper, index cards, and transcribed data will be shredded in a confidential shredder. Any data related to this study that is on a computer hard drive and USB stick will be deleted.

Contacts

If you have any question or concerns about this research study please refer to the contact information at the beginning of the consent form.

In addition, you may verify the ethical approval of this study or raise any concerns you might have by contacting the Human Research Ethics Office at [redacted]Phone [redacted] or e-mail [redacted] or by contacting the Research Ethics Office [redacted]

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers. A copy of this consent will be left with you, and a copy will be taken by the researcher.

Participant Name (Please Print) _______

Participant Signature___

Date___

Witness Signature_____

Date___

Appendix N

Team Meeting Consent

You are invited to participate in a study entitled How do ACT (Assertive Community Treatment) teams and teams using the principles of ACT support clients to attain and maintain housing? This study is being conducted by Shona Lalonde RN BScN.

My name is Shona Lalonde. I am a Master's Student in the Department of Nursing at the University of Victoria. If you have any questions about this research study you may contact me by phone or email.

[redacted] (Home) [redacted] (Cell) e-mail: [redacted]

I am conducting this research to fulfill requirements for the degree of Master of Nursing. My research is being conducted under the supervision of Dr. MacDonald. You may contact my supervisor at phone [redacted](office) or by e-mail [redacted]

Purpose and Objectives of This Study

The purpose of this research study is to gain an understanding of the complex work members of ACT teams do to support clients to attain and retain housing. Not only is there a lack of affordable housing, but severely mentally ill and or addicted individuals encounter many barriers to attaining housing. There are numerous situations that can lead to housing instability (e.g., decompensation in the client's mental health and client behaviour). The capacity of team members to pre-empt or ameliorate the challenges that lead to housing instability will be explored. The successes and barriers that ACT team members have experienced in housing clients and the factors that contribute to success will be examined. The services provided by team members that are specific to supporting a client's housing stability will be identified. The professional skills and strengths used by the multidisciplinary team will be explored. The participants' experiences and insights will guide this research study.

The Importance of This Research

The knowledge gained from this research study could possibly a) help define how team members can best supported in the work they do; and b) identify how clients can best be supported to attain housing stability. Identification of the challenges and issues the team members encounter could inform future actions from within the team, the health authority, and associated agencies. The identification of strategies to support clients in housing could lead to improved outcomes for clients. The results of this study, encompassing the unique perspective of the team members and their insights, will contribute to a larger a body of knowledge related to supporting the severely mentally ill and individuals who have problems with addictions in housing.

Participant Selection

You have been asked to participate in this study as you are a member of an ACT or an ACT-like team who work with clients who suffer from severe mental illness and / or addictions, who are homeless, or whose housing situation is unstable.

What is involved?

If you agree to voluntarily participate in this research study, your participation will include allowing me, the researcher, to sit through one of the team meetings, and b) take notes on any topics relevant to the research, and c) engage team members in a 30 minute question and answer session at the end of the meetings. The questions asked will focus on topics related to the research study. The question and answer session will be audio taped to ensure accuracy in the interpretation and analysis of data. The audiotaped discussions will be transcribed by myself or by a transcriptionist. Who is bound by a code of confidentiality. The transcriptionist's name is_______________________________. The transcriptionist listens to the audiotapes and writes down what was said this is done as an essential part of the data analysis process,

Inconvenience

Participation in this study may cause some inconvenience as it could extend the time spent in the team meeting.

Risks

There are no known or anticipated risks to participating in this research. However your participation may be very stressful and cause some feelings of anxiety. If there is tension or stress during the post meeting discussion we can take a break then resume the discussion. Along with this consent form you will find information about counseling services. Please be aware that you do not have to discuss topics or divulge information that you are uncomfortable with. If you are feeling stressed or no longer wish to participate you can withdraw from the discussion at any time.

Compensation

No financial compensation will be provided.

Voluntary Participation

Your participation in this research must be completely voluntary. You may withdraw from the study at any time without any consequences or penalty, and can do so without an explanation. If you withdraw from the study it will not be possible to remove data derived from your participation in discussion or from the database.

Researcher's Relationship with Participants

There is no power over relationship between the researcher and the participant. The researcher does not have supervisory capacity over the participant.

Ongoing Consent

The researcher may contact the participant to clarify information and to verify the researchers account of the interview. Continued discussion with the researcher remains voluntary and confidential.

Confidentiality

Due to the nature of the group activities i.e.a large group discussion at the end of the team meeting, the researcher cannot guarantee confidentiality amongst the participants. It is up to all participants to maintain confidentiality and not divulge what was discussed. Participants will be reminded at the beginning of our question and answer session that a) having signed the consent form you are agreeing to maintain confidentiality and b) the maintenance of confidentiality is a condition of participating in this study. Please do not divulge or discuss information during the question and answer session that you would prefer to keep private.

Anonymity

In the publication and dissemination of the research results reference will be made to Regional ACT teams and will not identify the teams. However readers who are familiar with the history of ACT in BC may identify this work as being based [redacted]. The anonymity of the participants will be maintained throughout the study.

To maintain participant anonymity, neither the participants' names or other identifying information will be included in published research or in the presentation of data. Information that could potentially identify an individual will be withheld. The participants' name will not be directly attached to any data (such as audio tape recordings, interview notes, memos, transcripts or data entered into the electronic data base). Each participant will be given a unique identification code. All data will be labeled with the participants' identification code. A document linking the identification code to the participant will be stored in a locked filing cabinet and I, the principle investigator, am the only person who will have access to the filing cabinet and the document.

Portions of de-identified data will be shared with my masters thesis supervisory committee and the Grounded Theory research group members as they will be guiding me through the data analysis process. One of the reasons for sharing the data analysis process is to ensure that I, as a researcher, derive my analysis from the data as opposed to my own preconceived ideas or bias.

The results of this research will not be used for commercial purposes.

Dissemination of Results

It is anticipated that the results of this study will be shared with others in the following ways:

- Presented to the participants prior to my defense.
- Published as a graduate thesis and available on line.
- Provided (in form of thesis) to the ACT teams and to the health authority.
- Presented at Scholarly presentations, conferences, and meetings
- Disseminated in journal articles.

Storage of Data

Once the data are recorded using an audio-recorder, the data will be transcribed by either myself or a qualified transcriptionist. The transcribed data will be entered into an electronic database. As part of the analysis process, the transcribed data may also be transferred onto index cards.

Neither the data entered into the data base nor onto the index cards will contain identifying information. Each data base entry and or index card will be labeled with a participant number.

The audiotapes will be retained for interpretation and ongoing analysis and validation. All audiotapes will locked in a filing cabinet at (my) the principal investigator's home. A USB drive will be used to back up the study data. The USB drive will not be used in any other computer except for my laptop dedicated for use during the research study. The laptop will be password protected and will be off when not in use. I will be the only person with access to the computer.

Disposal of Data

Following the publication of the thesis (expected January 2013), all data from this study will be disposed of. All documents such as paper, index cards, and transcribed data will be shredded in a confidential shredder. Any data related to this study that is on a computer hard drive and USB stick will be deleted.

Contacts

If you have any question or concerns about this research study please refer to the contact information at the beginning of the consent form. In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the [redacted] phone [redacted] or email [redacted] or by contacting the Health Authority Research Ethics Office at [redacted]

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers. A copy of this consent will be left with you, and a copy will be taken by the researcher.

Participant Name (Please Print) _______

Participant Signature___

Date___

Witness Signature_____

Date___

Appendix R Clinicians Script

I am asking your permission to allow me to bring someone with me on one of my visits to you. This person is Shona Lalonde, a Masters in Nursing student at the University of Victoria. Shona is doing research about the work I do as an ACT team member to support clients to get and maintain their housing. Shona is collecting information about what I do during the visit, for example, giving medication, checking how clients are doing, providing health information, and assisting clients with activities such as shopping, housekeeping, filling out forms and helping to sort out problems that might arise.

You are under no obligation to allow the researcher to come with me on a visit. You can say no. I will still visit you and be available to you whether you allow me to bring the researcher or not. The information recorded during our visit will be about what I do. There will be no information collected about you or that could identify you.

During the visit you can ask the researcher to leave at any time, especially if you need to talk with me privately. We can also agree on a signal that will let me know that you want the researcher to leave. When you signal I will ask the researcher to leave. I will also ask the researcher to leave if you look stressed or uncomfortable.

Date and time of visit

____

Appendix S

Study Synopsis

Shona Lalonde

[redacted]

[redacted]

[redacted] (Home)

[redacted] (Cell)

E-mail [redacted]

To whom it may concern,

This is a synopsis of the research study that I am conducting as a student researcher.

As a graduate student, I am required to conduct research as part of the requirements for a the Masters of Nursing degree. This study is being conducted under the supervision of Dr. MacDonald. You may contact my supervisor at [redacted] (office) or by e-mail [redacted]

Purpose and Objectives of This Study

The purpose of this research study is to gain an understanding of the complex work participants do to support clients to attain housing and remain housed. Not only is there a lack of affordable housing, but severely mentally ill and or addicted individuals encounter many barriers to attaining housing. There are numerous situations that can lead to housing instability (e.g., decompensation in the clients mental health and client behavior). The capacity of team members to pre-empt or ameliorate the challenges that lead to housing instability will be explored. The successes and barriers team members have experienced in housing clients and the factors that contribute to success will be examined. The services provided by team members that are specific supporting a clients housing stability will be identified. The professional skills and strengths utilized by the multidisciplinary team will be explored. The participants experiences and insights will guide this research study.

The Importance of This Research

The knowledge gained from this research study could possibly a) help define how team members can best supported in the work they do b) identify how clients can be best supported to attain housing stability. Identification of the challenges and issues the team members encounter could inform resolution from within the team, the health authority and associated agencies. The identification of strategies to support clients in housing could lead to improved outcomes for clients. The results of this study, encompassing the unique perspective of the team members and their insights, will contribute to a larger a body of knowledge related to supporting severely mentally ill and or individuals who have problems with addictions in housing.

Contacts

If you have any question or concerns about this research study please to not hesitate to contact me using the phone numbers or e-mail above. You are also welcome to contact my supervisor if you believe that this is necessary. This study will take place pending the completion of ethical review by the Human Research Ethics Office at the [redacted] (phone [redacted] or email [redacted]) or by contacting the Health Authority Research Ethics Office [redacted]

Sincerely,

Shona Lalonde RGN RN BScN

Masters in Nursing Student University of Victoria, BC.

Appendix T

Notice of Confidential Counseling[19]

CONFIDENTIAL COUNSELING

Free confidential counseling services are often covered by your employee medical insurance. Health authority staff can obtain information from the following website

[redacted]

Regional Police Department and the Ministry of Health and Social Development also provide this service through their Employee Family Assistance Program (EFAP). Please check your medical insurance and internal websites for information about this free confidential counseling

For participants who cannot access an EFAP here are the names of counselors who are fee-for- service.

Name of counselor- Office address-phone number-email

Name of counselor –Office address-phone number-email

Name of counselor-Office address-phone number-email

Health Authority Employee Family Assistance Program (EFAP)

Find out about confidential, short-term counseling, advice and information available to employees and eligible family members experiencing personal problems that affect their family life, work life or general well-being.

Services provided by PPC Canada 1-800-phone number

The EFAP provides professional assistance for a wide range of personal issues, including:

- Marriage, relationship and family concerns

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[19] The name of health authority and any information identifying the region of study have been removed.

- Alcohol and drug dependencies
- Career and work-related concerns
- Life transitions
- Stress-related problems
- Anger management
- Grief and bereavement
- Childcare and aging family concerns
- Sexuality
- Anxiety and depression
- Family violence
- Resource information and referral for financial and legal concerns
- Trauma response and critical incident stress debriefing

This service is completely confidential and counselors are located in all parts of the Authority as well as throughout Canada. Unless you tell them, no one at your workplace will know that you have used the EFAP.

The EFAP is an employee benefit. There is no charge to you or your immediate family to use the services. If long-term or specialized counseling is required, your counselor will refer you to a community resource you can afford.

For more information on the EFAP or other health and safety issues, please contact your nearest Health Authority Occupational Health & Safety Department office.

Appendix U

Transcriptionist Confidentiality

CONFIDENTIALITY AGREEMENT: TRANSCRIPTIONIST

I___________________________________have agreed to work as a transcriptionist on this study entitled "How Do Assertive Community Treatment (ACT) Teams and teams using the Principles of ACT Support clients to attain and Maintain Housing?"

The student researcher conducting this study is Shona M Lalonde Masters Student, University of Victoria, School of Nursing

Thesis Supervisor: Dr. Marjorie MacDonald.

I am signing this form agreeing that I will protect confidentiality in this study by assuring that the anonymity of each participant is maintained at all times. This will mean that each participant is assigned a number/letter that will be used on all tapes and written notes that apply to that participant so that her or his name and identity is protected. Thus, all identifying information within the transcriptions of the interviews that I transcribe will be deleted or alerted to preserve anonymity.

All research materials for this study will be kept secured in a locked filing cabinet in the researchers home. Any materials pertaining to the research project will be returned to the researcher (tapes, discs, original print outs, and copies) for storage in a locked filing cabinet in the researchers home office. I will also erase any materials pertaining to the research project form the hard drive of the computer I am using once the information is given to the researcher.

Finally, I will not, under any circumstances, disclose any information in the field notes or interviews to any persons or agencies, including staff employed by the health region where the study is taking place.

I have had the opportunity to discuss these requirements with the researcher Shona Lalonde and have received a signed copy of this confidentiality agreement. I hereby swear to uphold the confidentiality of any information learned by transcribing taped interviews.

Print Name: ______________________________

Signature: ________________________________

Date: ____________