Psychology and Public Policy: The Story of a Canadian Housing First Project for Homeless People with Mental Illness

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The views expressed herein solely represent those of the authors.

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Abstract

At Home/Chez Soi was a Canadian research demonstration project that tested the impacts of the Pathways Housing First model on people experiencing serious mental illness and homelessness in five cities across the country. In this article, we tell the 10-year story of At Home/Chez Soi, its positive outcomes, and how it contributed to transformative change in public policy from "treatment first" to "housing first" to end homelessness for individuals with severe and persistent mental illness. The lessons learned from this story demonstrate how psychology can influence public policy. In the policy arena, psychologists can play several roles, including conceptualizer/innovator, researcher/evaluator, partnership-maker, clinician/supervisor, policy advisor, knowledge translator, and advocate. All of these roles are important for making policy change. Implications for training in psychology are discussed.

Keywords: public policy, Housing First, homelessness, mental illness, transformative change

Public Significance Statements: Housing First is an approach to ending homelessness for people with serious mental illness. But like many evidence-based approaches, Housing First needs to be enshrined in public policy to maximize its impacts. The At Home/Chez Soi project showed that psychologists can play multiple roles in creating transformative policy change to promote the adoption and widespread implementation of Housing First in Canada to eliminate homelessness.

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More than 25 years ago, Marybeth Shinn (1992) entitled her Presidential Address to the Community Psychology Division of the American Psychological Association: "Homelessness: What Is a Psychologist to Do?". In this paper, we aim to show how psychologists can play multiple roles to influence public policy on important social issues like homelessness and mental illness. We do so by telling the story of the At Home/Chez Soi research Demonstration Project on the impacts of Housing First (HF) on people experiencing homelessness and mental illness in Canada. The At Home/Chez Soi project was important not just for its achieved positive outcomes, but also for its advocacy to influence changes in policy and practice. We explore the lessons learned from this story about the important contributions that psychologists can make in creating transformative policy change and the implications for training in psychology. We refer the reader to papers on At Home/Chez Soi that are cited in this paper for more information about specific research findings. We begin by providing some background on the issues of homelessness and mental illness in order to contextualize the At Home/Chez Soi project.

Background

In this section, we briefly review literature on homelessness and mental illness in Canada, psychology's contributions to community mental health for people with serious mental illness, HF, and policy change.

Homelessness and Mental Illness in Canada

According to Gaetz, Dej, Richter, and Redman (2016), there are approximately 35,000 people who are homeless on a given night and 235,000 who experience homelessness in a year in Canada. Moreover, Gaetz and his colleagues, observe that homelessness has become more widespread since the 1980s. Nelson and Saegert (2009) trace this rise in homelessness to the erosion in housing policy for low-income Canadians. In the 1980s, the federal government eliminated funding for social housing and downloaded responsibility for it to the provinces. In the 1990s, Ontario downloaded responsibility for social housing to the municipalities. Provincial and municipal initiatives were insufficient to meet the demand and a growing and visible homeless population was emerging across the country.

In response, the federal government created the Supporting Community Partnership Initiative in 1999 to address this issue, committing $753 million over a three-year period for cities to collaborate with government, and the voluntary and private sectors to address homelessness (Government of Canada, 1999). This initiative became the Homelessness Partnering Strategy in 2007, which provided funding of approximately $100 million per year to 61 Canadian communities to combat homelessness. Wide discretion was left to the communities as to how to use their funding that resulted in the expansion of shelters, transitional housing, and other programs for people experiencing homelessness. Federal policy at this time was not evidence-based, and an important goal of the At Home/Chez Soi project was to provide evidence on effective strategies to address homelessness that could guide policy.

Mental illness and addictions are prevalent among people experiencing homelessness (Canadian Population Health Initiative, 2009). In a study of 300 Toronto shelter users, Goering, Tolomiczenko, Sheldon, Boydell, and Wasylenki (2002) reported a lifetime prevalence rate of 67% for a diagnosis of mental illness and 68% for a diagnosis of substance abuse or dependence. Moreover, sub-groups of the homeless population who are characterized by lengthy periods of homelessness (those with chronic and episodic homelessness) have higher rates of mental illness and substance abuse or dependence than those who are temporarily homeless (Aubry, Farrelll, Hwang, & Calhoun, 2013; Kuhn & Culhane, 1998).

Community Mental Health, Clinical Psychology, and Community Psychology

With the advent of psychiatric deinstitutionalization in North America in the 1960s and 1970s, community mental health programs were developed for former patients of psychiatric institutions with serious mental illness. Clinical psychology was instrumental in developing principles and practices of psychosocial rehabilitation (Farkas & Anthony, 2010), and evidence-based practices like Assertive Community Treatment (ACT) (Bond & Drake, 2015) and supported employment (Bond & Drake, 2016) for people with serious mental illness.

Community psychology grew out of clinical psychology and was closely aligned with community mental health in the 1960s and 1970s. Early in its history, community psychologists argued that clinical psychology and community mental health were too narrowly focused on individual clients, their deficits, and clinical services (Sarason, 1976; Rappaport, 1992). Like clinical psychology, community psychology has emphasized evidence-based approaches, and has incorporated

programs like ACT (Kloos, Ornelas, & Nelson, 2014). At the same time, it sought a broader, more holistic approach to serious mental illness.

The values, assumptions, and practices (Prilleltensky, 1997) of a community psychology approach included an ecological perspective that views people in context, a focus on strengths and empowerment of consumers of mental health services, a greater reliance on self-help and peer support, the promotion of community integration, and an emphasis on social justice (Kloos et al., 2014). Community psychology was influenced by and aligned with the growing movement of mental health consumers (Brown & Rogers, 2014) and both research on (Davidson & Roe, 2007; Drake & Whitley, 2014) and lived experience of (Deegan, 1988) recovery from serious mental illness.

Psychologist Paul Carling (1990, 1995) took a community-oriented, disability rights perspective on housing for people with serious mental illness. Rather than professional experts deciding what type of housing people should live in, including new mini-institutions in the community that provide custodial care, Carling emphasized consumer choice over housing. He called this new approach "supported housing," which was characterized by the motto "choose, get, and keep" housing, and the principle that housing and support should be delinked or separated with consumers living in regular housing if it was in line with their personal preferences

Supported housing was a forerunner to HF, but in these early days it lacked a clearly articulated program model; it had not yet been applied to the growing number of people experiencing both homelessness and mental illness; and it was not well researched (Nelson & Macleod, 2017). Supported housing was an important

historical precursor to HF. In fact, an early article describing the HF model referred to it as 'The Pathways to housing consumer preference supported housing model" (Tsemberis & Asmussen, 1999).

From Treatment First to Housing First

The Pathways HF model was developed in New York City in the 1990s by clinical-community psychologist Sam Tsemberis (2016), a Canadian originally from Montreal. Tsemberis challenged the dominant model for people experiencing homelessness and mental illness, which has been variously called the "residential continuum," the "staircase" model, or the "treatment first" approach (Goering & Tsemberis, 2014). In this model, clients must move from more structured and intensive support programs to less structured, more independent housing. Moreover, clients must meet different criteria, including medication compliance and abstinence from alcohol and drugs, to demonstrate their "readiness" to move to the next level of the staircase. In contrast, HF emphasizes consumer choice over housing and treatment such that they can move directly into independent housing.

Rent supplements are provided to enable clients to afford normal market housing, and clinical services are provided in the form of ACT or Intensive Case Management (ICM) (Tsemberis, 2015). Tsemberis (2015) pulled together the early work on supported housing, combined it with ACT and ICM support models, as well as incorporating other evidence-based programs, like supported employment, harm reduction, and trauma-informed care. Moreover, the HF model is based on four principles: (a) consumer-driven services and immediate access to housing with no pre-conditions, (b) separation of housing and clinical services, (c) a focus on

recovery in service provision, and (d) an emphasis on community integration. The HF model was a paradigm shift or transformative change in the housing and mental health sectors, where traditional practitioners clung to the belief that many clients were not "ready" for housing, were incapable of making good decisions on their own, and needed treatment before they could become stably housed (Goering & Tsemberis, 2014; Padgett, Henwood, & Tsemberis, 2016).

Tsemberis and Eisenberg (2000) conducted research to evaluate the impacts of the new HF approach. The first study used a quasi-experimental design to compare 242 HF clients with 1600 clients using New York City's residential continuum. Over a five-year period, 88% of the HF clients remained housed compared to 47% of the comparison group. These initial findings were replicated in two randomized controlled trials (RCTs). Gulcur, Stefancic, Shinn, Tsemberis, and Fischer (2003) randomly assigned 225 homeless people with mental illness to HF or the residential continuum. Participants were followed up at six-month intervals for two years. HF participants were significantly less likely to be homeless or use psychiatric hospitals and incurred lower costs associated with housing than those in the control group. Another RCT was conducted in a suburb of New York City and followed 260 participants for four years (Stefancic & Tsemberis, 2007). HF participants were significantly less likely to be homeless than participants in the control group over the four-year follow-up.

The HF approach represents a transformative change from the status quo. Moreover, it had shown promising findings in initial research conducted by the founders of the program. However, the question remained as to whether HF could

be replicated by other researchers in different contexts, and whether HF could become not just an evidence-based program but lead to evidence-based policy to impact a larger number of persons experiencing homelessness and mental illness. The Canadian At Home/Chez Soi study provided the opportunity for both a large-scale replication conducted by other investigators and for knowledge transfer to influence public policy.

Transformative Policy Change

Public policy entails government taking a course of action to deal with issues that are relevant to the welfare of the population. Policy includes both broad parameters and funding, but also implementation of the policy into practice (Nelson, 2013). Recently, evidence-based policy has come to the fore, as some governments are increasingly relying on research evidence to inform policy decisions (Bogenschneider & Corbett, 2010). This trend squares well with psychology's long-standing commitment to empirical research and the rise in evidence-based practice in areas like clinical, community, and health psychology, as well as medicine.

While policy can be understood in terms of its adherence to research evidence, a contrasting perspective on the policy-making process is the discursive approach (Fischer, 2003). The discursive approach views policy as constructed within a political arena, with multiple players and competing agendas. A social problem, like homelessness and mental illness, does not neatly lead to an evidence-based policy. Rather, it must compete for policy attention with other pressing social problems (Hilgartner & Bosk, 1988). Claims-makers, including those with lived experience of the social problem, must seize upon windows of opportunity to

advance their agenda. The discursive approach pays attention to context, policy framing, discourse, and multiple stakeholders in the policy-making process.

While the evidence-based and discursive approaches to policy might be viewed as incommensurate, this need not be the case. Evidence points to the "what" of policy, while discourse is more pertinent to the "how" of policy. Moreover, evidence can and should play an important role in contemporary policy discourses.

Community psychologists have argued that it is important to distinguish between ameliorative versus transformative policy change (Nelson, 2013; Nelson, Kloos, & Ornelas, 2014). Ameliorative change seeks to improve policy, but leaves the values, assumptions, and practices of extant policy untouched (Prilleltensky, 1997). Transformative policy, on the other hand, strives for systems change in which the underlying premises of the policy and "the rules of the game" that guide the policy are challenged (Goering & Tsemberis, 2014). As was discussed earlier, HF is an exemplar of transformative change since it represents a paradigm shift in how to assist people to exit homelessness and achieve housing stability. In the following section, we describe how HF became a focal point for policy change in Canada through the At Home/Chez Soi project.

The Story of At Home/Chez Soi

In this section, we tell the story of At Home/Chez Soi. We, the story-tellers, are all psychologists with backgrounds in clinical and community psychology, who participated as researchers, trainers, and advocates for HF during At Home/Chez Soi and afterwards in follow-up activities stemming from this project.

In the Beginning

One of the founders of community psychology, Seymour Sarason (1989) argued that to understand social change, it is important to examine the period "before the beginning" of a change. To understand how the At Home/Chez Soi project came about, one must go back to 2008 when Canadian Senator Michael Kirby received a phone call from someone in a senior political position in the federal government. Kirby was the first Chair of the new Mental Health Commission of Canada that was created after the release of his report on mental health, *Out of the Shadows at Last* (Kirby & Keon, 2006). The problem relayed in the phone call to Kirby was that the upcoming 2010 Winter Olympics would put Vancouver's downtown eastside, replete with poverty, homelessness, and open drug use in the streets, in the spotlight of the world. What would Kirby recommend government do to help alleviate this problem, that could become a public relations nightmare for the Canadian government? Kirby was able to parlay this opportunity to address homelessness in Vancouver into a pan-Canadian research project with $110 million of federal funding (Macnaughton, Nelson, & Goering, 2013).

Kirby met with Dr. Paula Goering, a highly respected mental health systems researcher, to formulate a research demonstration project. Once the funding was secured and announced in the 2008 federal budget, Dr. Goering, with Dr. Jayne Barker of the Mental Health Commission, considered the nature of the research on people experiencing homelessness and mental illness that would be undertaken in this project. This led Goering to New York City, where she visited the Pathways HF program and its founder, Dr. Tsemberis. Goering's first hand observation of the HF program in action, coupled with a recent review of the research on permanent

housing and support models for people experiencing homelessness and mental illness, published by two Canadian community psychologists and one of their students (Nelson, Aubry, & LaFrance, 2007), helped to crystalize the focus of the research on HF.

Dr. Goering proceeded to assemble a national research team that included research teams from the five cities in which the project would operate. The research team included clinical-community psychologists who played leadership roles as Trainers, Research Leads at the sites, and Co-lead for the qualitative research. The research used a RCT design that compared HF with usual treatment (Goering et al., 2011). In addition to evaluating outcomes and costs, At Home/Chez Soi, as it was called, included an extensive qualitative research component that examined the project's conception, planning, implementation, outcomes, and sustainability (Nelson, Macnaughton, & Goering, 2015).

In line with the HF philosophy of consumer participation and empowerment, an important principle of the research was the involvement of persons with lived experience in all aspects of At Home/Chez Soi. People with lived experienced were involved in planning the project (Nelson et al., 2016), played an advisory role during project implementation at the sites through bodies such as Winnipeg's Lived Experience Circle and Toronto's Lived Experience Caucus (Van Draanen et al., 2013), and participated on the National Research Team and National Working Group. At each of the sites, consumers were also hired as researchers and peer support workers (Voronka et al., 2014). The range and depth of persons with lived

experience in At Home/Chez Soi was clearly a transformative departure from the traditional roles of consumers as solely clients or research participants.

In planning the research in the five cities, several obstacles were encountered (Nelson et al., 2013). Since the housing sector had little history of using research to inform policy and practice, some local service-providers thought that the funding should go exclusively to services, not research. Relatedly, there were some objections to the RCT design, which was seen as treating homeless people like human "guinea pigs." These concerns were eventually at least partially overcome when stakeholders came to understand that nothing would be taken away from anyone, but that in fact new services – HF – would be added and tested. Another familiar refrain from communities at the beginning was that they were already doing HF, which they weren't, or that they had their own programs that were as good or better than HF. This period of "before the beginning" was characterized by extensive education and negotiation by Senator Kirby and Drs. Jayne Barker (of the Mental Health Commission), Goering, and Tsemberis, who had joined the project as a researcher and trainer.

The Project Unfolds

The At Home/Chez Soi demonstration project involved a pragmatic RCT conducted in five cities across the country: Moncton, Montreal, Toronto, Winnipeg, and Vancouver. The overarching objective of the trial was to evaluate the effectiveness and cost-effectiveness of HF relative to the existing services in each of the cities over a two-year period. The study investigated delivering HF to two

different groups of people who were homeless with mental illness, those with high needs and those with moderate needs.

Research design, programs, and methods. Level of participants' needs was determined by a multiple instrument screening process conducted by trained interviewers (Goering et al., 2011). An algorithm was used to classify participants as high needs (requiring ACT services) if they met the following criteria: (a) a current psychotic disorder or bipolar disorder based on the Mini International Neuropsychiatric Interview (MINI) (Sheehan et al., 1998), (b) a score of 62 or lower on the Multnomah Community Ability Scale (MCAS), which is a measure of community functioning (Barker, Barron, McFarland, Bigelow, & Carnahan, 1994; Dickerson, Origoni, Pater, Friedman, & Kordonski 2003), indicating at least moderate disability, and (c) at least one of the following: two or more hospitalizations for mental illness in any one of the last five years, recent arrest or incarceration, or comorbid substance use based on the MINI. All other participants were classified as having moderate needs. High needs participants were randomized to HF with ACT or usual treatment, while participants with moderate needs were randomized to HF with ICM or usual treatment.

The HF approach examined in the research was based on the Pathways model described earlier (Tsemberis, 2015). All five sites, except Moncton, included at least one HF-ACT program and one HF-ICM program, as well as developing an additional arm in their study. For example, Toronto developed a HF- ICM program for ethno-racial populations (Stergiopoulos et al., 2012), and Winnipeg created an HF-ICM program for Indigenous people (Distasio, Zell, & Snyder, 2018). Because of

the small size of the community, Moncton had only one program, HF-ACT, that was used with participants with both high and moderate needs. However, it also included the provision of HF to a small rural sample whose outcomes were compared to a matched treatment as usual sample.

Interviews were conducted with participants at baseline, six, 12, 18, and 24 months and included a range of quantitative measures (Goering et al., 2011). These measures included the residential time line follow back (Tsemberis, McHugo, Williams, Hanrahan, & Stefancic, 2007) to assess housing, a measure of community functioning (the MCAS), and a measure of quality of life (Uttaro & Lehman, 1999).

At Home/Chez Soi also used qualitative methods. Qualitative interviews and focus groups were used to understand the conception (Macnaughton, Nelson, & Goering, 2013), planning (Nelson et al., 2013), implementation (Macnaughton et al., 2015; Nelson et al., 2014), and sustainability (Nelson et al., 2017) of the programs in the five cities. The reader is referred to these sources to learn more about the methods and findings of this research on the HF programs. As well, semi-structured interviews were used with a 10% sub-sample of the larger sample to examine consumer outcomes using qualitative methods. Baseline (n=219) and 18-month follow-up (n=197) interviews were used to examine changes over time between HF and usual treatment participants (Nelson et al., 2015).

Participants. A total of 2148 individuals participated in the study with 1198 randomized to a HF group and 950 assigned to receive treatment as usual (TAU) (Goering et al., 2014). Of the 2148 participants enrolled in the study, 950 (44.3%) had high needs while 1198 (55.7%) had moderate needs. One-third of participants

were women. All participants were diagnosed at study entry with a current mental illness (i.e., 34% with a psychotic disorder and 71% with a non-psychotic disorder) based on the administration of the MINI by trained interviewers (Sheehan et al., 1998). Sixty-seven percent were also diagnosed with a substance-related problem and over 90% reported having one or more chronic physical health conditions. On average, participants reported being homeless for almost five years (58 months). Twenty-two percent of the sample identified as Indigenous and 25% as being from some other ethno-racial group.

Program fidelity. The project strived to implement its HF programs with high fidelity to the Pathways model. Training and technical assistance were provided by Dr. Tsemberis and his staff to each of the HF teams regarding the HF model and how to implement it. As well, two implementation studies, that included fidelity assessments were conducted, one after 9-13 months of operation (Nelson et al., 2014) and another after 24-29 months of operation (Macnaughton et al., 2015).

A fidelity assessment team visited 10 HF programs on two separate occasions to conduct the assessments. Over the course of one day, HF managers, staff, and consumers were interviewed, a team meeting was observed, and 10 charts were randomly selected for review. The team used the Pathways HF Fidelity Scale (Stefancic, Tsemberis, Messeri, & Drake, 2013) that consists of 38 items that cover five fidelity domains (e.g., Separation of Housing and Treatment). Items were rated on a four-point scale, with one indicating low fidelity and four indicating high fidelity. The team discussed the data collected and came to a consensus on the final ratings for each item. The average fidelity scores across all items, domains, and

programs were 3.47/4 for the early evaluation and 3.62/4 for the later evaluation (Macnaughton et al., 2015). Each HF team was provided with guidance after the assessments as to how it could improve program fidelity.

Study outcomes. In line with the original research on HF in the U.S., it was found that HF was more effective than TAU in all five communities in ending homelessness for people and helping them to achieve housing stability (Aubry et al., 2016; Stergiopoulos et al., 2015). Over the course of the two-year study, HF participants spent 73% of their time stably housed compared to only 32% for those receiving treatment as usual. This effectiveness proved to be much the same for participants with a moderate level of needs and for those with a high level of need. HF participants with moderate levels of need reported greater improvements in their quality of life on the Quality of Life Interview-20 (Uttaro & Lehman, 1999) and were assessed as showing greater improvements in community functioning on the MCAS (Barker et al., 1994) over the two-year period of the study (Stergiopoulos et al., 2015). In comparison, HF participants with a high level of needs reported greater improvements in quality of life and were assessed as demonstrating greater improvements in community functioning in the first 12 months, but these differences in improvement between the two groups were no longer present at 24 months (Aubry et al., 2016). A recently published study of programs at the Toronto site found that the impacts of HF on housing outcomes persisted six years later, but there were no impacts on quality of life, community functioning, or substance abuse symptoms (Stergiopoulos et al., 2019).

The in-depth qualitative interviews focused on changes in participants' lives since entering the study. The analyses of these qualitative data included classifying the changes as being positive, negative, or neutral. Positive changes centered around three kinds of transitions, namely from being homeless to becoming housed, from home to community, and from the present to the future. Differences in life courses between the two groups were apparent in this qualitative data, with 68% of HF participants describing uniformly positive life changes compared to only 28% of individuals receiving treatment as usual (Nelson et al., 2015). In addition, 36% of individuals receiving TAU characterized their life course since entering the study as being negative versus only 8% of HF participants.

Cost-offsets. Cost-offsets associated with HF programs were also examined. On average, HF with ICM cost CaD $14,498 per participant per year (2011 CAD; Latimer et al., 2019). Based on a comparison to the TAU group, participants receiving HF with ICM reported a reduction in health, social, and justice-related services leading to a cost offset of CaD $6,628 representing 46% of the cost of the HF program. The largest cost offsets were with reduction in emergency shelter use and single-room occupancy with support. The HF programs with ACT in the trial cost CaD $22,257 per participant per year (Aubry et al., 2016). Compared to the TAU group, a reduction in health, social, and justice-related services led to an average net cost offset of CaD $21,367 making up 96% of the HF with ACT costs. The largest cost offsets for these individuals were the result of a reduction in hospitalizations for general medical conditions, emergency shelter visits, and incarceration.

The Aftermath

As At Home/Chez Soi moved to its conclusion in 2013, project members were preoccupied with the sustainability of the HF programs. A final report was completed (Goering et al., 2014); a documentary on the project with several films was produced by the National Film Board (Here at Home, 2012); and multiple and ongoing presentations were made to the federal and provincial governments, including the Prime Minister's Office, about the positive impacts of HF, the costs that were offset, and the need for sustainability. The federal government provided one year of additional funding for At Home/Chez Soi HF programs through 2014. A major challenge for sustainability was that provincial governments did not provide any funding for the demonstration project, so they had to be convinced to pick up the funding of these HF programs once federal funding ended. In the end, nine of the 12 HF programs received sustained funding from the provinces (Nelson et al., 2017).

With the knowledge transfer activities for At Home/Chez Soi, a significant change in federal policy occurred. The federal government was in the midst of a review of its Homelessness Partnering Strategy program. The government was not satisfied that funding from this program showed no impact in reducing homelessness in Canada. The success of HF demonstrated in At Home/Chez Soi, and independently in the province of Alberta (Seven Cities on Housing and Homelessness, 2017), was an appealing alternative. In 2013, the federal government made a change in the Homelessness Partnering Strategy program to emphasize HF. For the 10 largest Canadian communities, that receive the majority of funding (80%), 65% of their federal funding was to be allocated to HF, while 40% of the funding in the other 51 communities was to be used to implement HF. According to

stakeholders, this policy impact was related to the positive evidence that was produced, but also to the way those results were framed to key decision-makers. The involvement of key policy-makers in the research process enabled researchers to carefully craft impactful messages that emphasized cost-effectiveness as well as quality of life changes (Macnaughton, Nelson, Goering, & Piat, 2017).

With this change in policy, it became clear that Canadian communities expected to create new HF programs would need support to implement HF. The Mental Health Commission funded two initiatives to provide such support. The first was the creation of a *Housing First Toolkit* (Polvere et al., 2014). The toolkit is a knowledge transfer resource with practical materials about HF that communities can use to aid in implementation. The second initiative was a training and technical assistance program to help 18 communities implement HF. The program ran from 2013-2016 and was led by Dr. Tsemberis. Research on this program showed that with training and technical assistance that new HF programs could be implemented with similar levels of fidelity to the HF model that was achieved in At Home/Chez Soi (Macnaughton et al., 2018). Since 2017, the HF training and technical assistance program has moved to the Canadian Alliance to End Homelessness. It continues to be led by Dr. Tsemberis and Mr. Wally Czech, another psychologist, and has been expanded to serve more communities.

Another important knowledge transfer tool is that of networks that rely on peer support among service-providers. These networks can operate at a provincial level, like Alberta's Seven Cities (Worton, 2018) and the Ontario Housing First Regional Network – Community of Interest (Worton et al., 2019), or at regional and

local levels, like Ontario's Southwest Five (Worton, 2018). Networks such as these can help strengthen HF implementation capacity in communities through peer support, mutual learning, and advocacy.

The legacy of At Home/Chez Soi is not confined to Canada. HF is now expanding to other parts of the world, most notably to European countries. Modeled after At Home/Chez Soi, France conducted a four-city RCT of Housing First, Chez Soi D'abord, targeting individuals diagnosed with schizophrenia who experienced homelessness. The French trial also achieved positive results with 85% participants stably housed after being in the trial for two years with program costs offset completely through a reduction in hospitalizations and emergency shelter use (Estecahandy, Agha, & Roebuck, 2018). These findings have led to the French government scaling up HF to 20 cities in France over the next four years (Ministère de la Cohésion des territoires, 2017). Finland, which has HF as a centerpiece of its homelessness policy, is quickly becoming the first nation to eliminate chronic homelessness (Pleace, 2017).

Three International HF conferences have been held in Portugal, Ireland, and Italy over the past few years, and an International HF Network has been established. This network has led to a cross-national study of HF fidelity in nine countries with the findings published recently in the *European Journal of Homelessness* (Aubry, Bernad, & Greenwood, 2018). Study findings showed that HF programs throughout Europe and in the United States and Canada in a wide range of health and social service systems are able to show a high level of fidelity to the Pathways model with

clients achieving consistently impressive housing outcomes (Greenwood, Bernad, Aubry, & Agha, 2018).

The Future

In 2017, the Canadian government announced a National Housing Strategy (National Housing Strategy, 2017). The strategy called for a substantial reinvestment of the federal government in housing, a new portable housing benefit, and a goal of cutting chronic homelessness in half in 10 years. While laudable in many respects, there are significant "red flags" in this policy. First, there is no longer a requirement for programs serving people experiencing homelessness to use the HF approach. Second, the portable housing benefit, an indispensable part of HF (Pankratz, Nelson, & Morrison, 2017), must be sufficiently robust to help people who are homeless to access market housing in Canadian cities (Nelson & Aubry, 2017). The proposed housing benefit of $575 per month that was recently agreed upon by the federal and Ontario governments (Mathieu & Rider, 2019) will be helpful to Ontario communities, but the amount will be insufficient in some communities, like the Greater Toronto Area, where rents for a single unit are well in excess of $1,000 per month. Third, in current homelessness policy, ACT is disconnected from HF programs for people experiencing homelessness (Nelson & Aubry, 2018). This is problematic for people with high needs, including schizophrenia, bipolar disorder, and other forms of serious mental illness, who do not receive the intensive supports or health services that they need. Finally, as recently reported by the Office of the Parliamentary Budget Officer, the proposed spending in the National Housing Strategy for "Assisted Housing" will actually

represent a decrease in % of the GDP when compared to the 10-year period before the strategy was released (Office of the Parliamentary Budget Officer, 2019).

We have also seen a retrenchment to old ways of thinking and practicing, including plans for building new multi-service shelters with long-term care beds (e.g., Ottawa; Aubry & Sylvestre, 2017). As time passes from the heyday of At Home/Chez Soi, there appears to be a resurgence of non-evidence based practices in the housing sector (Aubry, Nelson, Page, & Bradshaw, 2019). What is needed is a re-invigoration of research into evidence-based policy and practices in homelessness and mental health and continued work by psychologists to influence public policy, as was done in the At Home/Chez Soi project.

Roles for Psychologists in Creating Transformative Policy Change

What does the story of At Home/Chez Soi have to do with psychology? And how can psychology contribute to policy change to address the pressing needs of people experiencing homelessness and mental illness in Canada? In this section, we discuss some of the roles that psychologists can play in creating transformative policy change based on the experiences of At Home/Chez Soi. We describe multiple roles that clinical and community psychologists, and indeed psychologists from other sub-disciplines (e.g., counseling psychology, applied social psychology) can play (Lavoie & Brunson, 2010; Nelson, 2013). In the early days of community psychology, Sarason (1976) wrote that community psychologists must be "Mr. Everyman," playing multiple roles that extend beyond the roles of researcher, diagnostician, and therapist that psychologists have traditionally played.

In an article published in *Canadian Psychology*, Lavoie and Brunson (2010) described five strategies and seven interventions that community psychologists use to develop and improve programs and policies. The strategies include applied research, consultation, training, creation of partnerships, and knowledge exchange. The types of interventions include conducting needs assessments, developing new programs, community organizing, program evaluation, capacity building in organizations, engaging in social action, and contributing to the development of new public policies. These strategies and interventions are valuable tools for psychologists seeking to influence public policy.

One role psychologists can undertake vis-à-vis policy change is *conceptualizer/innovator*. With respect to homelessness and mental illness, Tsemberis (2015) brought in a new way of thinking about this social problem. Community psychologists have emphasized the importance of reframing the definition of the problem for social change (Seidman & Rappaport, 1986; O'Neill, 2005), as the way a problem is initially defined typically dictates the solutions undertaken to address it. Tsemberis challenged prevailing notions about homeless people with mental illness being incapable of making good decisions for themselves or living independently in regular housing. He reframed homelessness from a moral failing or a deficit to a focus on strengths, a potential for recovery, and an emphasis on housing as a human right.

Drawing on the mental health consumer recovery movement (Deegan, 1988), psychological research on empowerment and control (Prilleltensky, 1994), needs assessment findings from the perspective of people experiencing homelessness

(Tsemberis, 2015), and evidence-based practices in psychosocial rehabilitation (Bond & Drake, 2016), HF was created as an innovative solution to homelessness and mental illness that emphasized consumer self-determination, empowerment, recovery, and citizenship (Sylvestre, Nelson, & Aubry, 2017). At Home/Chez Soi helped to reframe the problem of homelessness in Canada by implementing and researching an innovative approach – HF.

While conceptualization and innovation are important, good ideas need to be empirically tested. With their research training, psychologists are well suited to play the role of *researcher/evaluator* to inform evidence-based policy and practice (Lavoie & Brunson, 2010). Initial research on Pathways HF in New York City and surrounding suburbs by Tsemberis and colleagues demonstrated the positive impacts of this approach in reducing homelessness and hospitalization, relative to "treatment first" approaches (Gulcur et al., 2003; Stefancic & Tsemberis, 2007; Tsemberis & Eisenberg, 2000). The large-scale, multi-site At Home/Chez RCT conducted in Canada replicated and extended the findings of the original research in New York City.

Psychologists have skills in a variety of types of research, all of which were utilized in the At Home/Chez Soi research. In addition to outcome and cost-benefits evaluation, psychologists can contribute to policy change through implementation science, qualitative methods, and mixed methods (Lavoie & Brunson, 2010; Macnaughton, Goering, & Nelson, 2012). Particularly relevant to evidence-based policy like HF is the examination of program fidelity. There is a danger that when a program is scaled up that new programs drift from the core elements of the model.

In At Home/Chez Soi and follow-up knowledge transfer work, psychologists contributed to fidelity research on HF that can help to ensure adherence to the original model that produced positive outcomes (Aubry et al., 2018; Macnaughton et al., 2015; Macnaughton et al., 2018).

Another role that psychologists can play to influence policy is that of *partnership-maker* (Lavoie & Brunson, 2010). HF is a complex clinical-community intervention that includes several components that are implemented in multiple systems (Nelson et al., 2015). Using a systems approach (Worton et al., 2018), psychologists can emphasize the importance of creating partnerships for policy change and implementation. In the case of HF, for example, it is important to create partnerships that include both the housing and mental health sectors, as was done in At Home/Chez Soi (Nelson et al., 2019). Nelson and Aubry (2018) recently drew the attention of policy-makers to the gap between the housing and mental health sectors with respect to HF and ACT. Partnerships at the service level are particularly important for HF programs that use a case management model of support, because case managers must broker a variety of different services for their clients.

Psychologists can act as *clinician/supervisors.* This is a central role in the implementation and dissemination of complex clinical interventions such as HF-ACT and HF-ICM. Both ACT and ICM are well defined community mental programs that include specific requirements for staffing and caseload ratios. As the support and treatment component of HF programs, the treatment philosophy of these mobile teams represents a transformation from a traditional mental health services model to a consumer-driven approach. Psychologists played key roles in defining the team

philosophy and practice, as well defining a set of core competencies for team members. From traditional assessments and clinician-directed interventions, the psychologist as clinician/supervisor strives to ensure that HF teams adopt the practices of consumer choice, empowerment, trauma-informed care, harm reduction, and motivational interviewing (Tsemberis, 2015). These are some of the core competencies required for HF programs.

Psychologists can act as *policy advisor* to government decision-makers particularly in the context of the development of evidence-based policy-making (Lavoie & Brunson, 2010). Bogenschneider and Corbett (2010) note that when policy advisors and decision-makers cultivate a trusting relationship with one another, that decision-makers are more likely to call upon such advisors for research advice about policy options. Members of the At Home/Chez Soi research team provided policy advice to decision-makers in the Prime Minister's Office and provincial governments over the course of the project that helped to facilitate policy change emphasizing HF.

An increasingly important role and strategy for psychologists in policy and practice is *knowledge translator* (Lavoie & Brunson, 2010). Knowledge transfer has become prominent as a means of addressing the evidence-policy gap. Wandersman et al. (2018) have proposed an interactive systems approach to knowledge translation that includes the synthesis and translation system, the service-delivery system, and the support system. The synthesis and translation system includes user-friendly reports and resources like the *Housing First Toolkit* (Polvere et al., 2014). The service-delivery system refers to local services for the target population,

including the housing and mental health sectors. The support system involves training and technical assistance, networks, and other vehicles to support high quality implementation. This framework guided policy change implementation in the process of scaling up HF (Macnaughton et al., 2018) with psychologists playing lead roles in training and technical assistance and network creation.

Finally, psychologists can function as *advocates* for evidence-based policy in their dealings with decision-makers (Lavoie & Brunson, 2010). This is an important role to counter-act the widespread promotion of non evidence-based practices by other advocates. Such advocacy requires persistence and long-term engagement on the policy issue that is being addressed to cope with the ebbs and flows of policy change. As well, advocates can help to create "bottom up" change, as well as "top down" change, by bringing community stakeholders, including people with lived experience, into conversations with policy-makers (Sylvestre, 2014). Advocacy in the aftermath of At Home/Chez Soi has taken the form of policy briefs, letters to and meetings with politicians, radio and television appearances, and opinion pieces written for the press.

Implications for Training

The At Home/Chez Soi project was fortunate to be able to draw on psychologists and other professionals who were competent in the roles described in the previous section. Not only was the At Home/Chez Soi team able to play these roles, but they were more broadly competent in research and evidence-based practice in homelessness and community mental health.

It is our contention though that Canadian professional psychology training programs could be doing much more to educate psychology trainees in community mental health and the roles required to create policy change. A relatively recent survey of APA-accredited clinical psychology Ph.D. program directors showed that less than 15% of programs offered a course on serious mental illness (Mueser, Silverstein & Farkas, 2013). Of course, it is not enough to understand evidence-based practices for people with serious mental illness, or how to move knowledge into policy or practice. Developing the next generation of psychologists also requires helping them take on a more enlightened set of values that underlie the notion of recovery and the practice of programs like HF and prompt them to take action to influence public policy based on those values. Clinical and community psychology graduate students must be educated in the values, research, and practice of a community mental health approach that creates effective and empowering interventions.

Developing the next generation of clinical and community psychologists requires having faculty within professional psychology training programs who can not only offer coursework, but can also help connect their students to meaningful practicum settings where they can develop their competency more fully. A significant impediment to providing more training in community mental health within clinical psychology programs identified by Mueser et al. (2013) is a lack of clinical faculty whose work concentrates on people with serious mental illness. Thus, the most important recommendation for training is for clinical and community psychology training programs to hire one or more faculty who are active

scientist-professionals in the field of community mental health for people with serious mental illness and who are committed to public mental health services, not private practice for people who are often easier to work with. Once such faculty members are hired, then curriculum revisions are needed to expose students to issues of serious mental illness and community mental health through course work, practicum settings, and research experiences. As well, it is important to replace retiring clinical and community psychologists with people who are competent in community mental health, so that training capacity in this domain is sustained.

At Home/Chez Soi provides a good example of what can happen in training when there is a core group of clinical and community psychologists who are competent in community mental health. There were numerous opportunities for graduate students, including budding clinical and community psychology trainees, to take on the roles identified in the previous section for creating policy change. Several students had practicum placements, internships, post-doctoral fellowships, research assistant positions, and did theses and dissertations on the At Home/Chez Soi project. We hope there will be opportunities for these new leaders to move into positions where they can contribute their knowledge and mentorship to the next wave of psychology trainees.

Conclusion

In this paper, we told the story of the At Home/Chez Soi research demonstration project. In response to Shinn's (1992) question about what's a psychologist to do about homelessness, this project was instructive about the roles psychologists can play in influencing transformative changes in public policy.

Multiple roles for psychologists, each with a unique focus, were identified. The At Home/Chez Soi demonstration project provides one illustration of the valuable roles that psychologists can play in influencing policy regarding major social issues of the day. Years ago, Sarason (1984) argued that community psychology had largely missed opportunities to engage in public policy work. The story of At Home/Chez Soi adds to the growing literature that shows how psychology can play an important role in making policy change.

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