Array of Services for Homeless Mentally Ill in Six Canadian Cities: Non-Governmental Organizations' Contributions and Perspectives

Alain Lesage
Université de Montréal

Carol E. Adair
University of Calgary

Marie-Josée Fleury
McGill University

Guy Grenier
Douglas Hospital Research Centre

Charles Gaucher
Université de Moncton

Alain Lesage, Centre de recherche de l'Institut universitaire en santé mentale de Montréal and Department of Psychiatry, Université de Montréal, QC; Carol E. Adair, University of Calgary, Alberta, AB; Marie-Josée Fleury, Douglas Hospital Research Center, McGill University, QC; Guy Grenier, Douglas Hospital Research Centre, Montreal, QC; Charles Gaucher, École de service social, Université de Moncton, Edmundston, NB ; Tim Aubry, Centre for Research on Educational and Community Services and School of Psychology, University of Ottawa, ON; Carolyn S. Dewa, Centre for Addiction and Mental Health, University of Toronto, ON; Michelle Patterson, Simon Fraser University, Burnaby, BC; Julian Somers, Simon Fraser University, Burnaby, BC; Paula Goering, Center of addiction and mental health, University of Toronto, ON (deceased).

Carolyn S. Dewa is now at Department of Psychiatry and Behavioral Sciences, UC Davis, School of Medicine, California, USA.

In memory of Paula Goering RN, PhD, soul, and scientific leader of *At Home Project*. We acknowledge the essential project coordination and analyses conducted by Nan Ma, Alima Alibhay, Pierre Gosselin and Catherine Hume. In each province, the support of mental health directorates was essential, thanks to Claudette Bradshaw and Ken Ross (New Brunswick); André Delorme (Quebec); Brian Davidson (Ontario); Marcia Thompson (Manitoba); Kathy Pryce (Alberta); and Leslie Arnold (British Columbia). The project was financed by the CIHR program, Partnerships for Health System Improvement (PHSI) with the Mental Health Commission of Canada.

Correspondence concerning this article should be addressed to Dr Alain Lesage, Centre de recherche de l'Institut universitaire en santé mentale de Montréal, 7401 Hochelaga, Montréal, QC, Canada. H1N 3M5. Email: alesage.iusmm@ssss.gouv.qc.ca

doi:10.7870/cjcmh-2020-028
Published by Canadian Periodical for Community Studies Inc.

Tim Aubry
University of Ottawa

Carolyn S. Dewa
University of Toronto

Michelle Patterson, Julian Somers
Simon Fraser University

Paula Goering (deceased)
University of Toronto

ABSTRACT

During the period 2010–2011, when the At Home project was conducted, a questionnaire was sent to 420 non-governmental organization (NGO) key managers in six Canadian cities to enquire about their collaboration with public services and their perspective on the services for homeless people with serious mental illness (SMI). NGOs constituted a dense network of collaboration among themselves. With regard to public services, housing and shelters were two services that NGOs had frequent contact with, followed by the healthcare addiction sectors and, to a lesser extent, social service and the justice sectors. Education and employment were both located in the network periphery. In general, NGOs viewed housing availability and accessibility to health services as largely unsatisfactory. They called for better public support, coordination, and funding.

Keywords: homelessness, severe mental disorders, network, interorganizational collaboration, Housing First project

RÉSUMÉ

Alors que se déroulait le projet Chez Soi, entre 2010-2011, un questionnaire a été envoyé à 420 responsables d'organisations non gouvernementales (ONG) dans six villes canadiennes, afin d'établir leur collaboration avec les services publics et leur perspective sur l'ensemble des services aux personnes itinérantes. Les ONG constituent un réseau dense de collaboration entre elles. Parmi les services publics, ceux du logement et des refuges étaient les plus familiers des ONG, suivis par le secteur de la santé et des dépendances, et à un moindre degré les services sociaux et de la justice. Enfin, les contacts avec l'éducation et l'emploi étaient plus périphériques. En général, les ONG considèrent comme très insatisfaisants l'offre d'habitation et l'accès aux services de santé. Ils appellent à un meilleur soutien public, une meilleure coordination et un meilleur financement.

Mots clés : itinérance, troubles mentaux graves, réseau, collaboration interorganisationnelle, projet Chez Soi

Before the At Home project was launched over a decade ago, homelessness has emerged as a significant social problem that affects thousands of Canadians in cities across the country (Begin et al., 1999; Goering et al., 2011). Reports had emphasized the significant health consequences and costs of homelessness in

Canada (CIHI, 2007; Paterson et al., 2008). Furthermore, the prevalence of mental health problems and addictions among homeless individuals is significantly higher than what is observed in the general population (CIHI, 2007). Mental health problems among the homeless include mental illnesses such as psychosis and affective disorders and concurrent disorders such as substance abuse disorders and personality disorders (CIHI, 2007; Paterson et al., 2008). A recent survey of homeless individuals found severe mental disorders (schizophrenia, bipolar disorders) in 26%; substance use disorders in 39%; chronic physical disorders in 28% (Fleury et al., 2020).

Although people with serious mental illness (SMI) do not represent the majority of the homeless population, they are more likely to experience repeated episodes and longer periods of homelessness as well as require more health and social services than others experiencing homelessness (Aubry et al., 2003). Diversion of homeless SMI people in the justice system had occurred (Bland et al., 1998; Brink et al., 2001). A 6-year study of administrative databases in Ontario showed that 3% of police interactions involved offenders with SMI (Charette et al., 2014). In Quebec's prisons, Lafortune (2010) linked justice and health databases, and found that 6% of inmates had received a diagnosis of schizophrenia, yet only 0.4% of the population is treated for schizophrenia each year (Lesage & Émond, 2013).

In addition to public health, social services, justice and housing sectors, non-governmental agencies (NGOs) have been involved with homeless mentally ill. The history of the development of social and health services, the roles of NGOs deeply involved with homeless mentally ill will vary from city to city. NGOs include a continuous role of churches-based organizations like the century-old Salvation Army; an emerging role in the '80s of community organizations, some radical in relation to social critiques of psychiatry (Emerick, 2006; White & Mercier, 1991). The literature on services integration (Durbin et al., 2006; Mechanic, 1991; Provan, 1997) insist on the importance of developing strategies of referring, brokering, and collaborating mechanisms to link clients to services. Integrated services networks have been proposed as a strategy for better system integration (Fleury, 2005, 2006). Positive reports have emerged in the USA of lasting systemic changes, and interestingly in programs at the interface of justice and mental health (Sherman et al., 2004) and homeless mentally ill for the ACCESS project (Dennis et al., 2000; Steadman et al., 2002). A balanced mental healthcare system shall foster recovery of homeless mentally ill, and coordinate and offer a comprehensive array of differentiated services in the community (Thornicroft & Tansella, 2004). The World Health Organization (Saxena et al., 2007) indicated that the financing of the de facto mental health system remains also important to successful mental health reforms. It is possible to link greater resources availability at a catchment area or regional level, and capacity of an array of services to better meet the needs for care of severely mentally ill (Knapp et al., 2002). In comparing catchment areas in regions of Québec, (Fleury, 2005, 2006) found indications that local services integration, community orientation, but also total resources available, were associated with a greater capacity of programs for mentally ill to meet clinical and social needs.

The Mental Health Commission of Canada's (MHCC) At Home/Chez Soi (At Home) demonstration project was a five-year, $125 million federally funded initiative announced in 2008, for implementing the Housing First model of housing and case management/Assertive Community Treatment teams for homeless SMI in five Canadian cities (Goering et al., 2011; Tsemberis et al., 2004;). It followed the federal housing for homeless initiative of close to a billion dollars since 1999 (HRDC, 2009). The previous literature supports that the government of Canada is certainly heading in the right direction for this most disadvantaged group

in seeking evidence of effectiveness, acceptability, and implementation. The MHCC At Home demonstration project evaluation design involves using mixed methods including the experience of participants and mental health service and housing providers, the array of city/regional services used, and the attempt to identify critical ingredients of success or failure (Goering et al., 2011). It will also increase knowledge about the effectiveness and efficiency of this coordinated approach in a system context other than the US where the Housing First model has been tested so far.

As Thornicroft and Tansella (2004) argue, the main focus of most mental health services research was, until recently, on outcomes at the individual level and description of programs. The MHCC At Home demonstration project does not escape this tendency with its randomized clinical trial design to assess outcomes, and description of individual and staff experience in the innovative program (Goering et al., 2011). It will not assess and compare existing de facto systems of care for homeless mentally ill, their governance, coordination/integration mechanisms and funding, and how this may affect the positive outcomes at the individual's level as indicated in the literature.

The present project undertaken simultaneously with the MHCC At Home project in 2010–2011 aimed to provide system context. The specific objectives were first to describe the characteristics of the NGOs involved with homeless SMI; secondly, their array of collaboration with public health, social, housing, justice, and education sectors; thirdly, to gather NGOs' perspective of gaps in the de facto system of care for homeless mentally ill. The six Canadian cities include the two largest metropolitan areas in Canada: Toronto and Montreal. Vancouver was also part of the MHCC At Home project, whilst Calgary was the first Canadian city to launch a Housing First service, the model tested with the MHCC At Home project. Rounding out the six cities are urban areas of Winnipeg and Moncton that face more aboriginal, or rural to urban, population movements.

METHODS

Sampling

A potential of 528 NGOs likely to be involved with homeless mentally ill were originally identified through the researchers and MHCC At Home project site project coordinators. Further selection to core downtown organizations in Montreal, Toronto, Calgary, and Vancouver, reduced this number to 420 NGOs, including Moncton and Winnipeg, to which a survey questionnaire was sent to the responsible manager of the NGO identified either through their website or a phone call to the organization prior to sending the questionnaire. The data collection extended over six months in each city, in 2010–2011; on average, three recalls were done, unless a formal refusal was received; in four cities (Montreal, Moncton, Toronto and Calgary) a mid-survey meeting with key stakeholders enhanced the final recruitment at a mean of 54%, a range of 43%–64%, for a total of 228 respondents.

Data Collection

All NGOs were charities recorded by Canada Revenue Agency. Information about their budget and self-reported fields of activities is public and were retrieved from the Canada Revenue Agency website. The various fields appear in Table 1. In order to represent and compare the weight of the various activities by the

NGOs in each city, each main reported field of activity by the NGOs was weighted by the NGO's budget. The main activities' relative weight were then rank-ordered in each city, and the first 10 reported in Table 1.

Questionnaire. The survey questionnaire had been developed and tested first in Montréal (Fleury et al., 2014a). Adaptations for other cities involved including the specific names of each city's identified NGOs (see sampling described above) and specific names of public organizations were required for the collaboration section, but keeping the same questions that will be reported here. It covers, in addition to general information, sections on collaboration among the NGOs and with other public organizations, and sections on satisfaction with existing services in meeting the needs of homeless people, which are now more detailed.

The collaboration section questions reported here were "Please indicate the organizations with which you have significant ties or collaborations with or without formal protocols and/or agreements." The collaborations were subdivided considering (1) the interaction of NGOs with government service organizations (public services) and (2) the collaboration within NGOs. Satisfaction about the services characteristics offered to people who are homeless and satisfaction about the ability of types of organizations to respond to the needs of homeless people were rated on a 5-point Likert scale. These services characteristics and needs of homeless people were drawn from the literature (Fleury et al., 2014a) and are detailed in Table 3 and Table 4 with the mean satisfaction scores.

Social network analysis of the collaboration section of the questionnaire. UCINET is social network analysis software that enables illustration the relationships among network members both by means of visual graphics and by statistical analysis (Borgatti et al., 2002). In a network graph, each distinct organization is represented as a node, which are inter-connected to other nodes with a line, called a tie. A tie represents the presence, direction or strength of the relationship. The graphic representation of the relationships among members of a network allows readers to see whether there are one or more networks, and the symmetry of the relationships among members. All of the NGOs and public organizations were represented by a number for purposes of confidentiality. Five statistics were considered: *density, centrality, in-* and *out*-degree centrality and *diameter*. *Density* is the number of ties that are presented as a proportion of total possible ties. A higher density value reflects more ties. Density scores range between 0 and 1, which are expressed as percentage in the present study. A simple example is that if every organization is linked directly with every other organization, the density is 100%. *Centrality* refers to the number of ties or links one organization has to other organizations in the network in relation to other organizations' number of ties or links. The organization with the highest number of ties has the highest degree of centrality. It is also located in the most central part of the graph. *In-degree centrality* is the number of ties a given responding organization has been credited by the others, whilst *out-degree centrality* refers to the respondent organization reporting ties with the other responding organizations. Centrality scores for this measurement count as a percentage that range between 0 and 100%. *Diameter* statistics relate to the popular six degree of separation paradigm, i.e., a human being on earth can be linked to six or fewer otherwise unrelated people; it represents the average number of ties to link each respondent NGO of a given city.

Interpretation of the graphic appearance and various statistics scores is not well standardized, even though terms have been suggested (Hawe et al., 2004). A perfect symmetrical and unique web would reflect an integrated network. Dekker (2008) reported that the centrality score indicates the position of an organization in a network: the most and least central organizations' scores depend on the percentage of ties in a given

network. Centrality score for a whole network translates to the degree of collaboration and integration of the entire network. As an example, the density in other studies using a social network analysis in AIDS or primary care reached the 30% range (Kwait et al., 2001; Scott et al., 2005). In a paper describing primary care organizations, Scott et al. (2005) stressed that equilibrium between in- and out-degree would reflect a more coordinated, less hierarchical network of organizations.

Ethics approval was obtained from the main researcher's university institute, but also from each of the six cities' researchers. Each questionnaire received was accompanied by a signed consent form by the respondent. Researchers committed to presenting and validating anonymous results to the stakeholders/respondents in each city first. In all cities, we received validation of our results, further comments, and authorization to present the results nationally.

RESULTS

The Canada Revenue Agency records the various areas of activity, possibly more than one, and overall budget without breakdown by area of activity, as reported by NGOs. In order to give more weight to the representation of the city's larger NGOs, the reported main area of activity of each city's NGOs was weighted by the budget. Their global budgets varied from $250,000/year on average in smaller cities, to $2.5 million in larger ones, with ranges in each city for Winnipeg ($12,000–$39 million), Vancouver ($107,000–$28 million), Montreal ($98,000–$47 million), Calgary ($19,000–$47 million), Moncton ($60,000–$7 million), Toronto ($23,000–$193 million). For each city, 10 most frequently reported main areas are rank-ordered; some weighted main categories were not frequent enough to appear in the first 10. This rank encompasses 10% to 18% of the NGOs' activities in each city. The self-reported main area of activity of the original 420 surveyed NGOs, weighted by their respective budgets, appear in Table 1. The category label is the one used by the Canada Revenue Agency. The *A* category was for *social services, F* for *health-related services* and *H* for other sectors. The four most frequent sub-categories across the cities were A1 housing for low-income people, those with disabilities; A8 children and youth services/housing; A7 services for the physically and mentally challenged; F6 addiction services and supports groups. The specific category of shelters (A10) was present in each city, but did not dominate the NGOs' activities.

The 228 responding NGOs did not differ, with minor exceptions, from the rank order of the 420 surveyed NGOs that the Canada Revenue Agency categories showed in Table 1. They reported being mostly created in the period 1981–1990, even though some were a century old. On average, they welcome between 25% and 50% of homeless people, about 60% men, in the 25–50 age group. Figure 1 illustrates the interaction and collaboration amongst NGOs. All the organizations represented in the graph are linked in this network by direct or indirect ties. The statistics associated with the graphic were as follows: The highest in-degree centrality was estimated at 32.4% for Moncton, followed by 27.5% for Montreal, 26.4% for Vancouver, and 25.8% for Calgary. Winnipeg and Toronto had an in-degree centrality of less than 20.0% (17.3% and 15.8% respectively). Compared to in-degree centrality, out-degree centrality was relatively high in all cities. Winnipeg and Montreal demonstrated the highest rates at 67.3% and 65.6% respectively, followed by Vancouver with 53.8%, Calgary with 40.5%, Moncton with 39.6% and Toronto with 23.5%. Moncton showed the highest level of density at 0.8, followed by Montreal (0.5), Vancouver (0.4), Calgary (0.4), Winnipeg (0.4), and Toronto (0.2). Diameter statistics measure the speed of access to information and service resources.

Table 1

Self-Reported Main Area of Activity of the NGOs Weighted by their Respective Budget

CAL	%	MON	%	MTL	%	TOR	%	VAN	%	WPG	%
A1	17	A8	34	F6	23	A3	13	A1	26	F6	20
A7	16	A13	13	A2	13	A1	13	A8	20	A7	15
A8	12	A1	10	F8	11	A8	12	A10	7	A1	13
A10	12	F8	8	H9	11	H9	11	A11	6	A10	9
A2	9	H9	8	A8	6	F5	7	F6	5	A8	9
F6	4	H10	5	A5	5	A10	7	F5	5	A9	6
A3	4	A10	5	A12	5	F8	5	F9	4	A2	6
A5	4	A2	3	A10	5	A2	5	A2	4	F3	4
A12	3	F9	2	F5	4	A11	5	A9	3	A3	2
F3	3	E5	2	F9	4	A6	4	A5	3	A11	2
Total	86		90		86		82		82		86

Note: CAL = Calgary; MON = Moncton; MTL = Montreal; TOR = Toronto; VAN = Vancouver; WPG = Winnipeg; A1 = Housing-seniors, low-income people & those with disabilities; A2 = Food or clothing banks, soup kitchens, hostels; A3 = Employment preparation and training; A5 = Other services for low-income people; A6 = Seniors' services; A7 = Services for the physically and mentally challenged; A8 = Children and youth services/Housing; A9 = Services for aboriginal people; A10 = Emergency Shelter; A11 = Family, crisis and financial counseling; A12 = Immigrant aid; A13 = Rehabilitation of offenders; F3 = Clinics; F5 = Mental Health services and support groups; F6 = Addiction services and support groups; F8 = Promotion and protection of health; F9 = Specialized health organizations focusing on specific diseases/conditions; H9 = Day care/After school care; H10 = Crime prevention, public safety

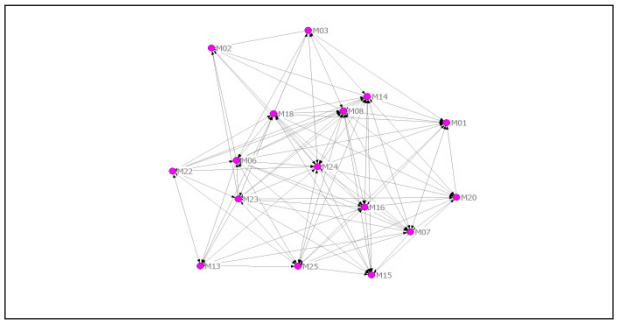
Calgary and Moncton had the shortest path diameter of 3, followed by Montreal, Winnipeg, and Vancouver at 4, and Toronto with the longest diameter of 6.

Table 2 indicates the out-degree centrality statistics of collaboration between NGOs and types of public services. The statistics of the density of collaboration between NGOs and all these public services were 71.0% (Vancouver), 61.8% (Moncton), 59.5% (Montreal), 57.1% (Calgary), 50.0% (Toronto), and 44.8% (Winnipeg).

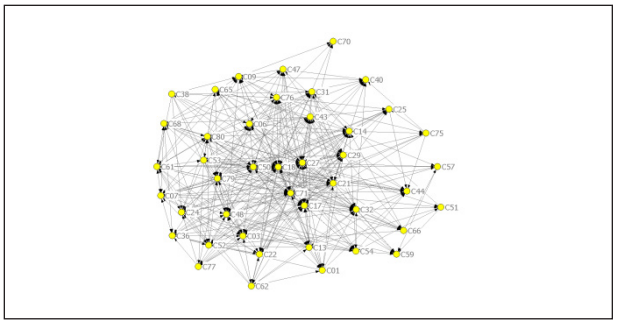
Tables 3 and 4 show the satisfaction with the ability of existing services organizations to respond to the needs of homeless people and with the offer of services to homeless people in their city. Satisfaction was rated on a 1 (very dissatisfied) to 5 (very satisfied) scale. Such questions on satisfaction tend to attract scores above 3.5, and with not much variation (Perreault et al., 2006). We would warn against comparing precise scores between cities, since there were not independent assessments across the cities—each city should be considered separately, with its response's style, and compared overall on scores' tendencies and relative ordering of dissatisfaction.

Figure 1

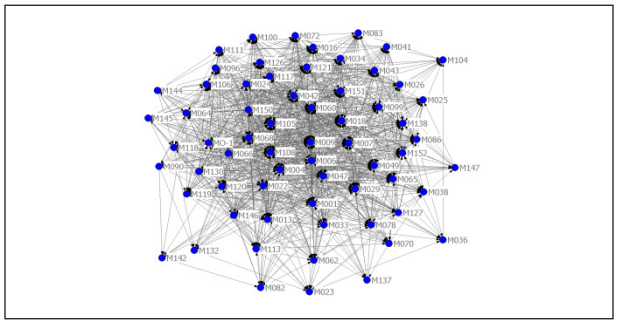
Significant Ties/Collaborations amongst NGOs



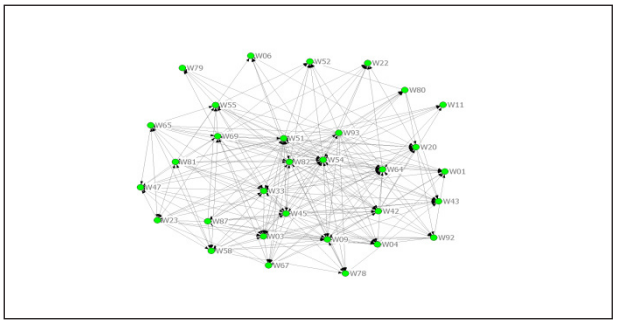
Moncton



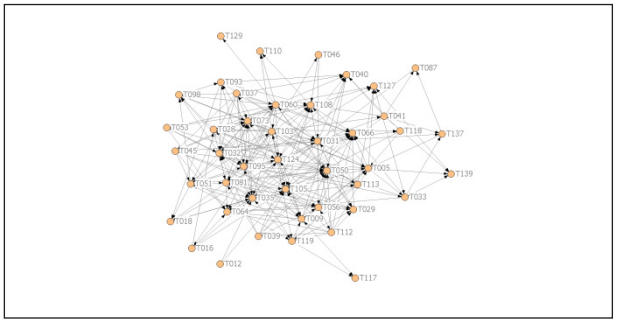
Calgary



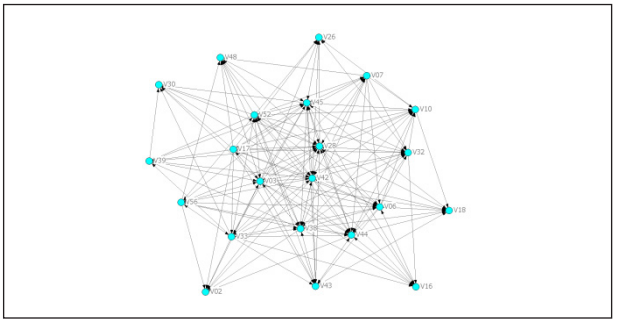
Montréal



Winnipeg



Toronto



Vancouver

Table 2

Degree Centrality of Collaboration between NGOs and Public Services

City	A.S.	E.E.I.S.	Hosp.	Housing	Justice	M.H.	Shelter	S.S.	M.C
MON	68.8	50.0	56.3	75.0	75.0	81.3	75.0	87.5	37.5
MTL	73.4	42.2	57.8	67.2	54.7	50.0	73.4	50.0	43.8
TOR	43.2	45.5	59.1	59.1	52.3	52.3	50.0	36.4	52.3
CAL	47.8	54.3	45.7	63.0	58.7	54.3	73.9	58.7	37.0
WPG	32.3	38.7	45.2	51.6	51.6	48.4	41.9	48.4	45.2
VAN	72.7	77.3	81.8	86.4	68.2	72.7	59.1	50.0	77.3

Note: CAL = Calgary; MON = Moncton; MTL = Montreal; TOR = Toronto; VAN = Vancouver; WPG = Winnipeg; A.S. = Addiction services including addiction centers, recovery centers, special detoxification centers and rehabilitation support; E.E.I.S. = Education, employment and income support sector including school board, post-secondary institution, local, provincial, employment services, provincial income support programs, as well as Service Canada; Hosp. = Emergency rooms, urgent care centers and hospitals; Housing = Municipal and provincial housing, private housing and other housing programs; Justice = Justice sector including municipal and provincial police services, Royal Canadian Mounted Police (RCMP), municipal and provincial jails and municipal tribunals; M.H. = Mental health including psychiatric hospitals, community mental health clinics, psychiatrists, the At Home/Chez Soi project, crisis or outreach teams and the health sector of forensic; Shelter = Any type of shelter for men, women, and family; S.S. = Social services including youth centers and other social service programs; M.C. = Medical clinic including community health centers, HIV/AIDS clinics, and physicians

Table 3

Opinion about the Ability of Service Organizations to Respond to the Needs of Homeless People

Services	VAN	TOR	CAL	MTL	MON	WPG	Avg
Public housing	2.05	1.84	2.19	1.91	2.1	1.5	1.93
Emergency (wait time)	2.1	2.13	2.66	1.97	1.87	1.8	2.09
Private housing	1.89	2.1	2.66	2.65	2.23	1.5	2.17
Housing services	2.47	2.3	2.58	2.31	2	1.7	2.23
Banking services	2.11	2.31	2.72	2.69	2.41	1.8	2.34
Employment support	2.17	2.54	2.79	2.65	2	2.1	2.38
Legal services	2.26	2.74	2.76	2.69	2	1.9	2.39
Housing support services	2.63	2.55	2.58	2.42	2.18	2	2.39
Rehab & social integration services	2.26	2.69	2.88	2.53	2.37	2	2.46
Intensive case management	2.5	2.52	2.79	2.60	2.36	2.2	2.50
Crisis intervention (on site)	2.18	2.57	2.97	2.70	2.77	2.3	2.58
General advocacy	2.76	2.77	3	2.61	2.1	2.5	2.62
Day and evening centers	3.16	2.68	2.94	2.92	2.19	2.2	2.68
Community support	3.11	2.75	2.94	2.55	2.82	2.5	2.78
Outreach programs	3	2.86	3	3.09	2.88	2.4	2.87

Note: VAN = Vancouver; TOR = Toronto; CAL = Calgary; MTL = Montreal; MON = Moncton; WPG = Winnipeg; Avg = Average

Table 4

Opinion about the Array of Services Offered to People Who Are Homeless

Services	VAN	TOR	CAL	MTL	MON	WPG	Avg
Access to family doctors	1.63	2.15	2.29	1.53	1.47	1.7	1.80
Access to psychiatrists	1.65	1.94	2.12	1.88	1.88	1.9	1.90
Wait time for services	2.00	2.27	2.27	2.20	1.93	1.7	2.06
Opening hrs on the weekend	2.00	2.33	2.56	2.32	2.53	2.2	2.32
Access to other health professionals	2.06	2.44	2.57	2.51	2.56	2	2.36
Opening hrs in evening and night	2.32	2.23	2.73	2.44	2.38	2.1	2.37
General access to services	2.53	2.5	2.62	2.41	2.29	2.2	2.43
Quantity of services available	2.86	3.18	3.16	2.61	2.84	2.2	2.81
Variety of services	2.84	3	3.18	2.86	2.88	2.6	2.89
Opening hrs during day Mon to Fri	3.11	3.39	3.21	2.98	2.47	2.8	2.99
Quality of services	2.95	3.48	3.13	3.11	3.06	2.7	3.07

Note: VAN = Vancouver; TOR = Toronto; CAL = Calgary; MTL = Montreal; MON = Moncton; WPG = Winnipeg; Avg = Average

DISCUSSION

With budgets ranging from $250,000/year on average in smaller cities, to $2.5 million in larger ones, NGOs' reported activities appear to offer services relevant for homeless individuals with SMI: housing and services for people of all ages with physical, mental, and addiction problems. The system to which NGOs belong, in partnership with public services, is not responding well to the needs of homeless individuals. Questions on satisfaction tend to attract scores above 3.5, and with not much variation (Perreault et al., 2006). Overall, great dissatisfaction was expressed by NGOs in each city about the system meeting the needs of homeless people and on the array of services offered to homeless people, since the highest score was 3.07 and the lowest 1.8. The answers converge remarkably across all cities to indicate greater dissatisfaction with housing and waiting time for services, whilst crisis intervention and outreach were better developed, but still below the tipping point of satisfaction. There was also a parallel ordering of the least satisfactory to the less dissatisfactory across the six cities, with access to health services being particularly deficient everywhere, but quality of available services (including presumably the responding NGOs themselves) receiving a better approval. Yet, existing NGOs constitute a dense network and they collaborate with each other, with some diversity among cities. The graphic for all cities' NGOs shows collaboration appears symmetrical, dense, and with all NGOs related more than once, many times with each other, it reflects a well-integrated network. The higher density than that reported in the literature by other AIDS or primary care network results, is also testimony to the quality of collaboration, except in one city showing distancing. In interpreting the latter, it is as if some NGOs were not from the same city and operating in isolation from other NGOs. The gap between in- and out-degree centrality in most cities would reflect less coordination in the otherwise dense network. From the site perspective, NGOs in Vancouver showed relatively high frequency contact with almost all public services, with the highest score of density of 71% among six cities, where scores ranged from 44.8% to 71%. Such density of NGOs with public services could be considered comparable to the over 50% out-degree scores found in each city between the NGOs themselves, indicative of existing dense and integrated network collaboration. Scores of degree centrality with specific public services ranged from 36% to 86.4%, which would be indicative of varying collaboration and involvement of the NGOs with those public services, but also between cities. Moncton followed Vancouver and displayed a closer relationship, centrality, with public services (mental health 81.3%, both shelters and justice sectors at 75%, addiction services 68.8%) and this was also reflected with their higher density scores of 62% and 71%. Moncton is also the site with the highest social services score (87.5%). Addiction services and shelters initiated the most frequent contacts in Montreal (73.8% and 73.4%), followed by housing (67.2%), hospital and emergency room (57.8%), and justice (54.7%); whereas in Calgary, shelters had the highest score (73.8%). Housing showed as the first demand in three cities: Vancouver (86.4%), Toronto (59.1%), and Winnipeg (51.6%). Winnipeg and Toronto demonstrated a lower interaction between NGOs and the public services sector, as indicated by the lowest centrality and density scores. For Toronto, it was also coherent with the lowest out-degree centrality and diameter statistics between the NGOs themselves.

This study took place during the At Home demonstration project and was aimed at providing the system context where the project took place in five Canadian cities. The present study informed not on the At Home project itself, but on the system level; over 50 other studies documented especially the individual and program level of At Home (Aubry et al., 2015). At the individual level, the efficacy was tested through a pragmatic

randomized trial that demonstrated increased housing tenure (Stergiopoulos et al., 2015). Also, the National Film Board interactive site (NFB, 2020) shows interviewed At Home participants in their own smart apartments thanks to the program's support to rent, evidencing the improved quality of life compared to shelters or the streets. At the program level, cost-benefit analysis showed At Home was efficient at $60/day (Latimer et al., 2020). A cost analysis revealed that average annual costs (excluding medications) per person in the homeless mentally ill control group who were not offered the intervention in the five cities ranged from 29, $610 in Moncton to 58, $972 in Toronto. More interesting is the finding that yearly expenditures occurred in the array of services and sectors explored at the system level: almost a quarter for hospital stays, a quarter for police and incarceration, 10% for shelters, and a quarter for social assistance/benefits (Latimer et al., 2017). The sustainability of the At Home project was explored by Nelson et al. (2017) through interviews with key stakeholders in each city. They found that nine of the 12 At Home programs (75%) were sustained, and that seven of the nine programs reported a high level of fidelity. Factors that promoted or impeded sustainability were broad contextual (i.e., dissemination of research evidence, the policy context); community (i.e., partnerships, the presence of At Home champions); organizational (i.e., leadership, ongoing training, and technical assistance); and individual (i.e., staff turnover, changes, and capacity).

The At Home project has opened a movement to end homelessness for SMI, but has been met with some scepticism by NGOs (Fleury et al., 2014b). The present study would support the potential of existing NGOs to implement in collaboration with public services, improved outreach and housing for the homeless SMI evidenced by At Home project. First, we found in each city that a remarkable array of NGOs operate in Canadian cities for the socially disadvantaged of all ages with physical and mental handicaps, including homeless, and emerged over 40 years ago, even though some were century-old. This reminds us that destitution, homelessness, and institutions have been a constant issue since industrialization and urbanization in Canada. These NGOs are not only shelters; actually, most are not presenting themselves as such to the Canada Revenue Agency, but certainly have important housing and addiction activities for the homeless.

These NGOs form remarkably integrated and dense networks in each city. They collaborate among themselves and with public services more than what was observed in the literature examining AIDS or primary care networks (Kwait et al., 2001; Scott et al., 2005). However, coordination between NGOs, and to some extent with public services showed asymmetry that may point towards difficulty in being recognized or the existence of "cliques" (Fleury et al., 2014a). NGOs work remarkably collaboratively, with some exceptions, and with respect to feedback of results, confirmed as a group how their network functions and indeed their difficult access to other services for individuals, especially health services. They also indicated a tension between the recognition that no single approach will meet the needs of all homeless mentally ill; that an array of accessible, individually tailored, tolerant, and flexible services is required. Yet there is a need for a more holistic approach, a common vision and governance, and strong collaboration among sectors to meet those needs. This shall not come as a surprise. Relationships between social services where most NGOs of this survey are identified, and health services, with their different governance and values, have been associated with gaps in meeting the needs of complex disadvantaged populations (Leutz, 1999). Moreover, NGOs' precarious funding and turnover, often dependent on public agencies, low recognition, and different philosophy of care has jeopardized the existence of an equal partnership with the public services, but push for more collaboration among NGOs (Guo & Acar, 2005). In a more detailed analysis of Montréal's networks, Fleury

et al. (2014a) concluded, using Whetten's framework on the types of network coordination (Whetten, 1981), that the current structure of Montréal's homeless organization network is of the "mutual-adjustment" type. Under this last form of coordination, the exchanges among homeless organizations are generally voluntary and imply no formal means of coordination.

LIMITS

This project took place at the time of the At Home demonstration project in 2010–2012, but did not represent an evaluation of the demonstration project itself. It was aimed at describing the homeless mentally ill de facto care system and reported opinions of all NGOs about care and services in their respective cities, whether they had actively supported the At Home project or not. Reports from the At Home project are still being published after 10 years (for example, Latimer et al., 2020), so the present system's context study remains relevant. The perspectives of NGOs are illuminating but cannot be seen as having precedence over other legitimate stakeholders like public health and social services planners and providers, the justice system, the housing and private sector, but also the homeless mentally ill themselves, their families, and citizens who have a daily experience with homelessness in their cities. For example, a contemporary study on satisfaction with services by homeless in Montréal showed a mean score of 4.1; satisfaction was greater in relation to NGOs than public health services (Gentil et al., 2020). We were not able to show all of the potential 420 NGOs' activities with the public domain listed by the Canada Revenue Agency; we were limited in reporting the main activities without knowing the proportion of the budget for other activities of each NGO. The response rate of 50%, 228 respondents, could be of concern, especially in the social network analysis. However, since each respondent provided information on all other potential NGOs, including non-respondents, the approach is closer to a qualitative paradigm of saturation than a quantitative approach's representativeness. In addition, validation studies have shown that the particular metrics we reported, like centrality and density, in- and out-centrality, remained stable with response rates varying from 40% to 70% (Valente, 2010). Our interpretation of the satisfaction with services was cautious to avoid using statistics to compare scores between cities. We agreed to present the results to each city's stakeholders committee, so as not to misrepresent what they reported—and they all confirmed the general dissatisfaction with the functioning and how the system was not responding well to the needs of homeless mentally ill. But comparing the scores between cities would suggest that it is an independent assessment, which it is not; it is embedded and validated only in each city. Secondly, even though collaboration is considered in the health and social services literature as better, other factors like the overall financial resources are also paramount, and greater collaboration may be a reflection of greater financial constraints, whilst independence may keep or attract more funding globally.

CONCLUSIONS

The current Covid-19 pandemic has revealed the existing deficits in health and social services for mentally ill in Canada (McGrath et al., 2020). The past situation as illustrated in this study and the current pandemic one are more akin to a human rights situation—systemic underfunding, discrimination when accessing health, social services, and housing—show homeless mentally ill are shunned (Thornicroft, 2006).

The very first recommendation of the Royal Society of Canada is for an increase of the mental health and addiction budget allocation from 6% to 12% in each province (McGrath et al., 2020; Jacobs et al., 2018). Such increased funding would fund public health and social services, but also NGOs which currently receive 10% of the health and social services mental health expenditures (IHE, 2014; expenditures section at ihe.ca). In coordinating this increased public allocation of funding in provinces, supported by a major social housing push by the Canadian government, it shall not disregard the experience of individually, socially, and culturally tailored approaches and perspectives of NGOs, which collectively represent the safety net and tireless advocates for the homeless in our cities. Their dedication and capacity for networking collaboratively in general in most Canadian cities, very close to homeless mentally ill, shall represent the bedrock of increased funding and collaboration of cities' health, housing, social, and judiciary sectors to create the dense network that will lift severely mentally ill out of homelessness towards their recovery and citizenship.

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