Canadian Mental Health Association Sudbury/Manitoulin | Association canadienne pour la santé mentale Sudbury/Manitoulin

Conseil des Services du District de Manitoulin-Sudbury District Services Board

Final Evaluation Report:

Manitoulin-Sudbury District Services Board (DSB) & Canadian Mental Health Association- Sudbury/ Manitoulin (CMHA-S/M)

April 1 2016 – March 31, 2017

May 2017

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Background

According to the Canadian Mental Health Association, mental illness is increasingly recognized as a serious and growing problem. It is estimated that 1 in 5 Canadians will develop a mental illness at some time in their lives. Many more individuals such as family, friends and colleagues are also affected.

Mental illness is the term used to refer to a variety of mental disorders that can be diagnosed. Mental disorders are health conditions that are characterized by alternations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.

Mental health means striking a balance in all aspects of one's life: social, physical, spiritual, economic and mental. At times, the balance may be tipped too much in one direction and one's footing has to be found again. Everyone's personal balance is unique and the challenge is to stay mentally healthy by keeping the right balance.

The Manitoulin-Sudbury DSB staff have developed a relationship with the Canadian Mental Health Association through a variety of committees at various levels. During meetings of the Espanola Health and Community Services Planning Network, a solution to assist with ongoing issues relating to mental health of residents was proposed. Although current resources are helpful, a need for greater services could better assist tenants and help void the gap.

In December 2015, the Canadian Mental Health Association- Sudbury/ Manitoulin (CMHA-S/M) and the Manitoulin-Sudbury District Services Board (DSB) met to discuss a partnership pilot project between the organizations. A letter of intent was developed and outlined the scope of the work that was identified and how it would be implemented.

The DSB identified a need for Mental Health supports in their buildings in the Espanola / Manitoulin areas and as they did not provide this service were looking to partner with the CMHA - S/M to provide the service. CMHA - S/M provides Transitional Community Support services in Sudbury by meeting individuals in their homes or in the community who are at risk of losing their housing or starting to feel unwell and needing additional support services.

The outcomes initially discussed for the project were:

- Less landlord/tenant complaints
- Increased retention of tenants – less turnover
- Reduced episodes of hoarding, bed bugs (environmental issues)
- Increased landlord and tenant awareness of community supports available
- Increased referrals to support programs (life skills, education, and child care)
- Increased participation in employment/ volunteering and/ or related programs or activities

The proposed start of the pilot project would be January 2016 and spending till March 31st, 2016 on program set up (hiring, work plan development, policy development, etc.). The staff would start working with individuals from April 2016 until March 31, 2017. **The funding would come from DSB and the Northeast LHIN. DSB would pay $60,000 and through CMHA surplus dollars the NE LHIN would contribute $30,000 towards this pilot project. CMHA also agreed to provide in-kind support to the pilot project valued at $15,000.**

CMHA would also explore an evaluation process for the program in order to report on our findings in early 2017. The evaluation would assess if the pilot should be recommended for implementation into an annualized funded program.

Partnerships with Purpose

The Manitoulin-Sudbury DSB identified a need for Mental Health supports for Social Assistance recipients and other residents residing in DSB Social Housing properties in the Espanola / Manitoulin areas. As a result of this, a partnership with CMHA was formed to address the need. CMHA currently provides Transitional Community Support services in Sudbury by meeting individuals in their homes or in the community who are at risk of losing their housing or starting to feel unwell and needing additional support services.

The intent and purpose of the pilot was for the Transitional Community Support Worker to meet social assistance recipients and other social housing tenants to provide short term supports and housing stabilization through linking individuals to community resources. The Transitional Community Support Worker will be available to residents when the need arises.

A partnership agreement was developed between both organizations to define roles and responsibilities. The pilot project and spending from January - March 31st, 2016 was for program set up (recruitment, work plan development, policy development, etc.) was provided by CMHA – S/M. Once the Transitional Community Support Worker was hired in March, they began orientation and then developed a work plan. The staff started working with individuals from April 2016 until March 31, 2017 with the possibility of extension.

The funding to provide this service for social assistance recipients and other residents will come from DSB's Ontario Works Employment Support funding envelope and the Northeast LHIN. The estimated cost of the pilot will be $90,000 and the DSB will fund $60,000 and the Northeast LHIN through CMHA will fund $30,000 and CMHA will provide in-kind services valuing approximately $15,000. (Please note that if the program continues on an annual basis, additional funds will be required for administrative services, employee benefits, pensions, etc.)

The Ontario Works Employment Supports budget (94.2% provincial and 5.8% municipal) included $37,066 for Mental Health and Addictions The balance of $22,934 will be re- allocated within the same funding envelope and staff will ensure the approved budget is maintained.

The program will aim to prevent, address and reduce homelessness by improving access to adequate suitable, affordable housing that is linked to support services based on individual needs. The staff will provide short term supports through linking individuals to community resources. Individuals would receive assistance to enhance daily living skills, maintain their wellness and living environments to reduce crisis, hospitalizations, and homelessness.

Moving the Project Forward

- DSB & CMHA-S/M identify a need to establish a solution to assist with ongoing issues relating to mental health of residents
- Concept is supported by NELHIN & DSB Board

- Measures developed
- Recruitment of candidate starts

- Orientation and set up of employee
- Policies and procedures are established that meet both agency needs

- An agreement, including financial commitment, from partner agencies is reached
- The program goes live

- Engagement with paramedicine program (August)
- Location at set buildings for availability & rapport building
- New measures developed and refined

- Review of program and evaluation or learnings, successes & challenges

Transitional Community Support Worker Role

Transitional Community Support (TCS) program being offered in Espanola/Manitoulin was initially formed to provide support services to individuals who were living in social housing units provided by the Manitoulin Sudbury District Service Board (DSB). Individuals being referred to the program were initially being identified by the social housing provider who recognized that additional support was needed in order to maintain their housing. As the pilot progressed it became evident that individuals were not ready or feared accessing services as offered. We identified the need to offer services in a way that allowed some individuals to self-refer and allowed others to have access to brief services in order to build rapport.

The Transitional Community Support Worker (TCSW) began working out of the social housing units, being on-site at scheduled times in order to be able to provide services to any individuals in the building. This allowed the TCSW to become a presence and a familiar face in the building, which made individuals feel more comfortable with approaching the worker for a supportive conversation when needed. Being in a rural area individuals had difficulties identifying what resources were available to them. It became evident that the TCS program was not only needed for individuals whose tenancy was at risk but also for those who needed additional support but were unsure how to move forward. The TCSW was able to start providing individuals access to brief services including supportive listening, goal planning and information and referrals to Community Resources that were available to them.

The Transitional Community Support pilot project was developed to offer both brief services and continued support to individuals within the social housing units offered by the Manitoulin Sudbury District Service Board. In the summer, it was identified that the TCSW could participate in the Community Paramedicine program, where the multi-disciplinary group could offer proactive health support to individuals and allow individuals to become comfortable with the support services available. The TCSW also accessed the Mental Health Services in Espanola, where CMHA is co-located, one afternoon per week. This allows the TCSW to debrief with co-workers and to complete paperwork and administrative duties as necessary.

A day in the life of a TCSW starts with picking up refreshments for the community paramedicine program and participating in the program with the paramedics at the social housing units. The TCSW offers services to individuals on their caseload within the building and remains available onsite for those individuals within designated buildings rotationally based on the need identified by the DSB. This offers individuals who drop in to have support and resources available as needed by the TCSW.

Measures

There are currently 9 measures in placed that allow us to evaluate performance outcomes on an individual, program and system level. In December there was an amendment to the agreement to reflect the revised stats and revised metrics.

1. **Less Landlord/Tenant Complaints**
   The goal is to address the issue before a notice has to be given.

2. **Increased Retention of Tenants – less turnover**
   The goal is to reduce the issues so that tenants remained housed.

3. **Reduced Episodes of Hoarding/Bed Bugs:**
   - # of cases referred for hoarding
   - # of people supported with hoarding
   - # of people progress/ resolved with hoarding
   - # of cases referred for bed bugs
   - # of people supported with bed bugs
   - # of people progress/ resolved with bed bugs

4. **Increased Landlord and Tenant Awareness of Community Supports Available:**
   - # of community resources provided to tenant

5. **Increased referrals to support programs:**
   - # of referrals to life skills
   - # of referrals to education
   - # of referrals to child care

6. **Increased brief services to individuals:**
   - # of brief services to individuals

7. **Increased participation in employment/ volunteering and/ or related programs or activities:**
   - # of participants referred to employment/ volunteering and/ or related programs or activities
   - # of individuals attending employment/ volunteering and/ or related programs or activities

8. **Decreased Police Calls in our buildings from the past year**

9. **Decreased Paramedic Services (PS) calls in our buildings from the past year**

10. **Qualitative information:**
    - Tenant stories (successes and challenges) to be added through survey feedback
    - Workshops will be added to evaluation as an unexpected value from the partnership

Summary of Outcomes - April 1, 2016 - March 31, 2017

Case Load

45 tenants supported, many required support in multiple areas as follows:

Areas of Support Provided	
Bed Bugs	2
Hoarding	5
Assistance with cleanliness	10
Activities of Daily Living	12
Mental Health	32
Addiction	8
Other Health Issues	19
Childcare	4
Legal	4
Budgeting / Financial concerns	7
Education / Volunteering	7
Employment	9
Landlord Issues	6
Other	14

Summary of Support Needs of Individuals (in case management)

Summary	
1 area of support	9 Tenants
2 areas of support	5 Tenants
3 areas of support	14 Tenants
4 or more areas of support	17 Tenants
Total Case Load	**45 Tenants**

This speaks to the complexity of issues and challenges faced by the individuals being served. An example is when an individual is referred for risk of homelessness. The TCSW could meet with them and aside from rental arrears identify that there are mental health, addictions, sexual assault and daily living supports that are needed as well. The TCSW would work on the presenting issues as decided within the

meeting with the individual however other issues would be referred to other agencies and resources within the community including longer term case management.

Profile of Individuals Served through Brief Services

171 not uniquely identified tenants were supported through brief services. Brief services are brief, time limited (1-5 visits) intended to screen and assist in identifying concerns an individual may have, which could include: providing information, referral to other organizations, and answering general inquiries based on individual need. Brief services are provided in the building common rooms and also in conjunction with the Community Paramedicine program. Partnering with the Community Paramedicine program provided a safe space for tenants to engage and an opportunity to build trust with the Transitional Community Support Worker.

Profile of 171 not uniquely Identified Tenants Served	
Age Group	Youth: 0
	Adults: 90
	Seniors: 78
	Unknown or recipient declined: 3
Gender	Female: 100
	Male: 62
	Other / not disclosed: 9
Heritage	Aboriginal: 11
	Other: 160
Identified Health Concerns	Anxiety Disorders: 10
	Developmental Disability: 2
	Mood Disorders: 28
	Other Mental Health: 34
	Psychotic Disorders: 6
	Physical: 41
	Unknown or recipient declined: 50
Reason for Service	Activities of Daily Living Skills: 3
	Advocacy: 23
	Required Support/Access to Services: 98
	Resources: 10
	Other / General: 37

Referrals to Community Agencies

This provides the number of referrals to other services that were made by the TCSW. It also depicts the diversity and complexity of issues facing and challenging to the individuals served. This may also speak to the challenges of lack of resources within a rural community.

Agency	# of Referrals	Total # Referrals
Childcare		
Manitoulin Family Resources	9	
Total Childcare		9
Education/Volunteering		
Cambrian College -Espanola/Little Current	7	
March of Dimes	10	
Sudbury Worker Educ. & Advocacy Ctre.	3	
Total Education/Volunteering		20
Health/Medical		
Espanola Family Health Team	30	
Health Care Connect	15	
Link to Life	14	
March of Dimes – Support Services	2	
Massey Gentle Exercise Program thru clinic	8	
Medical Cannabis Clinic	10	
Mental Health & Addictions - 90 Gray St.	13	
NE Acquired Brain Injury	2	
NE Community Care Access Ctre.	10	
Robinson's Pharmasave Walk In Clinic	3	
Sudbury Counselling Ctre - Credit Counselling	6	
Sudbury Counselling Centre - male survivors	2	
Total Health/Medical		115
Housing/ Financial		
Direct Funding Program	1	
Leeds County Social Housing	1	
Manitoulin Sudbury District Service Board	3	
ODSP Special	4	
Sudbury Housing	4	
United Way Tax Clinic	1	
Total Housing/ Financial		14

Life Skills / Assistance			
	Angel Bus	1	
	Assistive Devises Program (ADP)	2	
	Can. Hearing Society	1	
	Canadian Hard of Hearing	1	
	Community Living Espanola	1	
	Espanola Complex Social/Rec Programs	21	
	First Nation Housekeeping Services (AOK)	1	
	Independent Living Centre	1	
	Northern Initiatives for Social Action	1	
	Northshore Tribal Council - cultural services	1	
	Private Housekeeping Services	3	
	Sudbury Community Legal Clinic	7	
	VON Adult Day Program	3	
	VON Housekeeping	5	
	Total Life Skills / Assistance		49
Miscellaneous			
	CAS Lawsuit	11	
	Library	2	
	Man. Community Legal Clinic	1	
	Total Miscellaneous		14
	Total Referrals		**221**

Paramedicine Program

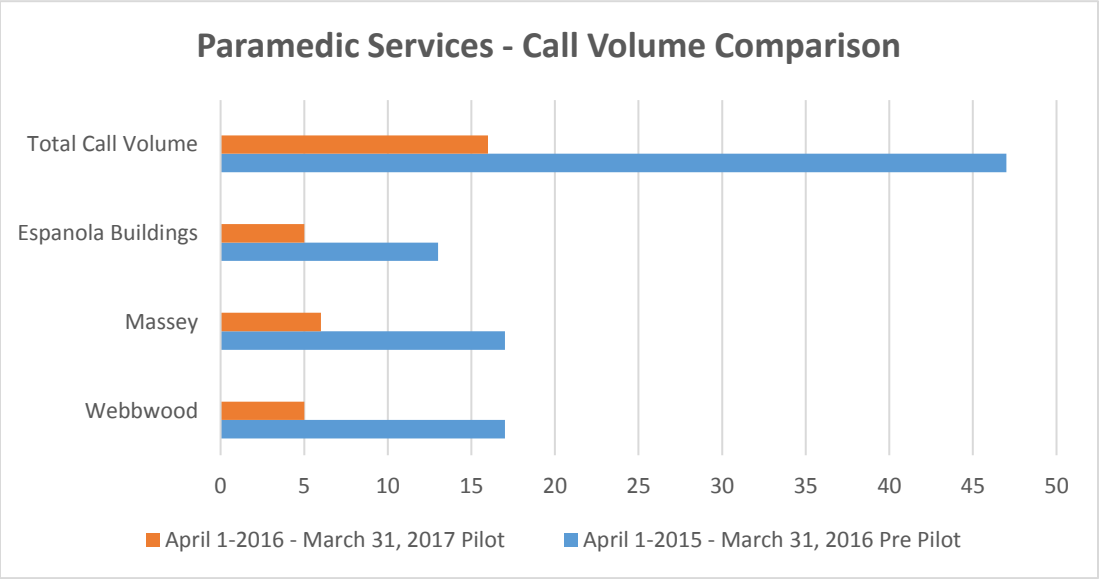
The TCSW started participation in the Community Paramedicine Service in August 2016. The stats below highlight the participation until March 31, 2017. All sites total for 2016/ 17 is 634.

* Participation stats were not gathered from Nov 22/16 to Jan 2/17
* The Community Paramedicine program started later in Manitowaning and Gore Bay locations
* n/a represents that the program did not operate that day

Week Ending	70 Barber St. Espanola	410 Bell St. Massey	10 O'Neil St. Webbwood	3 Water St. Gore Bay	76 Wellington, Manitowaning
05-Aug-16	5	2	9		
12-Aug-16	4	5	9		
19-Aug-16	4	12	10		
26-Aug-16	5	10	8		
02-Sep-16	6	8	9		
09-Sep-16	5	7	8		
16-Sep-16	5	8	10		
23-Sep-16	7		10		
30-Sep-16		7	9	4	4
07-Oct-16	8	8	5	2	2
14-Oct-16	7	8	5	2	2
21-Oct-16	4	8	10	1	2
28-Oct-16	3	9	10	1	2
04-Nov-16	5	7	13	1	2
11-Nov-16	6	8	11	2	2
18-Nov-16					3
06-Jan-17	n/a	7	11	n/a	2
13-Jan-17	3	5	13	2	2
20-Jan-17	5	5	9	1	3
27-Jan-17	4	7	13	3	2
03-Feb-17	2	6	13	n/a	3
10-Feb-17	5	7	12	2	1
17-Feb-17	4	6	10	3	n/a
24-Feb-17	4	6	7	5	n/a
03-Mar-17	n/a	6	n/a	2	n/a
10-Mar-17	4	5	12	1	3
17-Mar-17	2	7	5	3	n/a
24-Mar-17	3	7	11	n/a	n/a
31-Mar-17	3	6	10	1	1
Total:	113	187	262	36	36
Average:	4.52	6.93	9.7	2.12	2.25
Total Participants All Sites					**634**

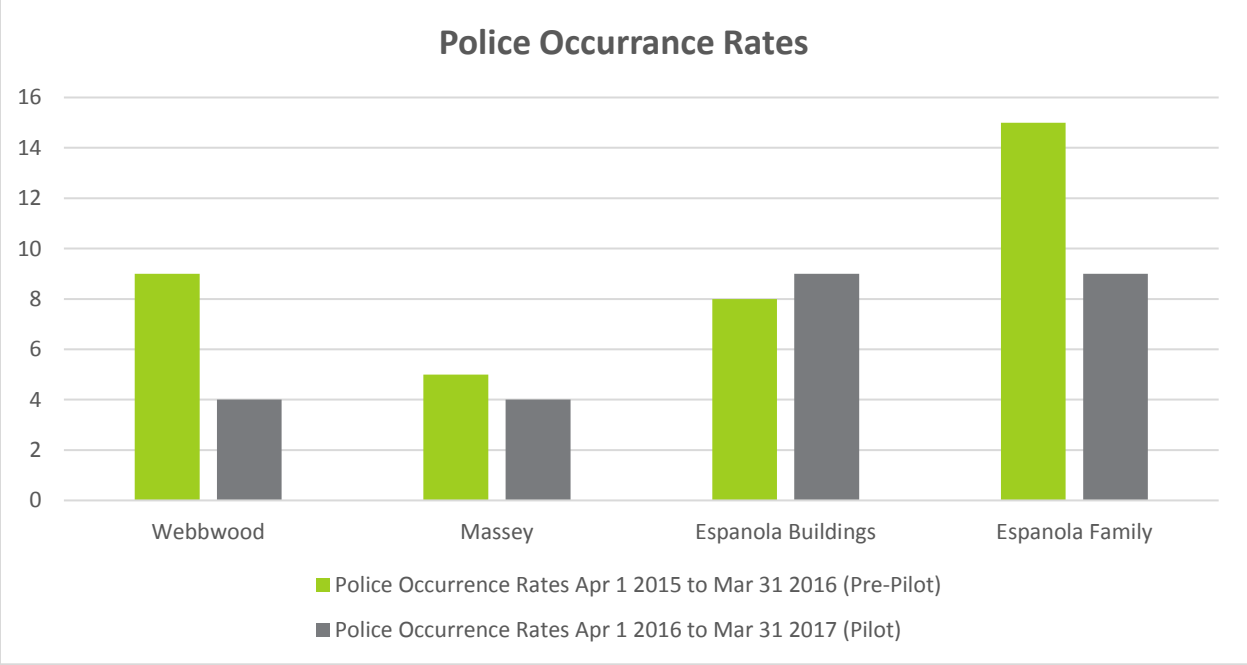
Paramedic Services Calls/ Responses

Paramedic Services calls from April 2016 - March 2017 by area/profile for Lacloche apartments only.



Police Occurrence Rates

The police rates provided for each geographical area summarize the calls to the buildings and not necessarily to the tenants specifically supported through the Transitional Community Services Program. This unfortunately means that although there are comparative statistics from year to year, we cannot deter direct or indirect correlation to the population group served by the program.



System Impact Survey

Survey data compares the tenants' involvement with EMS, crisis services, hospital, police, LTB or risk of eviction/homelessness. All individuals were asked to complete a survey pre and post service, however not all individuals surveyed have completed them due to refusal, or choice.

22 tenants were supported for 6 to 9 months, and agreed to participate in a pre and post support survey. The survey asked tenants to reflect on their involvement with specific emergency services and/or their risk of homelessness for the 3 months prior to receiving support services. The same survey was conducted at the end of support services.

The system impact demonstrates the positive impact and quality of life individuals experienced from receiving services.

How often did you experience the following:	In the 3 months prior to receiving support?	During the 6-9 months that you received support?
Use of Emergency Medical Services (EMS)	10	2
Admitted to Hospital	9	3
Crisis Line or Warm Line *	90	12
Involvement with Police	1	0
Risk of Homelessness	13	1
Notice of Eviction	1	0
	124	**18**

*Note: "Crisis Line or Warm Line" - one individual would utilize multiple times daily

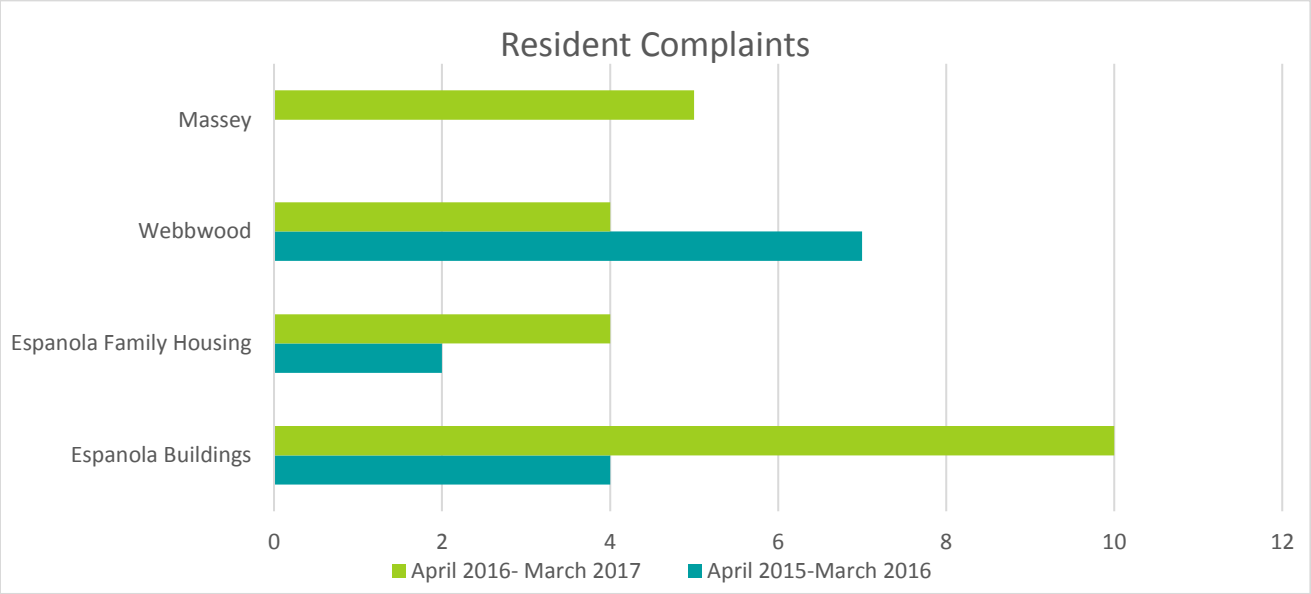
Resident Move Outs

Please note that the information regarding move outs is reported for all residents in the buildings and not only those who participated in the TCSW program. The most common reason provided for move out was health. The 2nd most common reason was unit transfer due to mobility or being over-housed.

After the one year pilot, 5 out of the 45 tenants have moved out, but none for reasons other than personal (job/health, etc.) This is indicative of the impact support services within an individual's housing environment can assist to stabilize and maintain their housing.

Resident Complaints

Please note that the data reported is for all housing residents and not only those residents that are registered in the TCS Program. Resident Complaints do not include anything related to maintenance. Resident complaints may include: neighbour dispute, noise, animals, unauthorized resident or their guests, clutter/cleanliness, hoarding or behavior.



Statistical information pertaining to resident move-outs and complaints are generalized and are impacted by availability of Services such as hospital in the area. Of the move-outs recorded for the Pilot period, the majority were due to health. None were in relation to services provided by the TCSW. Complaints from residents are again impacted by local services including hospital/clinic services and some service areas retain hard-to-serve clientele which results in more calls for services during key times.

Individuals Stories and Feedback

Story 1: A couple shared with me that through the program they have been able to regain some independence thanks to the advocacy and support offered by the Transitional Community Support Program and the paramedics who attend the Community Paramedicine Program. The couple identified that without these supports they feel unsure of where they would currently be in their lives. The individuals shared that their apartment was not supporting their health and was posing more danger to them, requiring them to access support (that could sometimes become expensive) from a number of people and resources.

Story 2: During the Community Paramedicine Sessions an individual who accesses the program learned that they have been living with high blood pressure. Thanks to the program they were able to recognize the pattern of their blood pressure and bring this information back to the doctor, who has since prescribed blood pressure medication. The individual shared that she did not recognize the symptoms

she was having as being related to high blood pressure but now feels the positive effects of having a lower blood pressure (less headaches, more energy).

Story 3: An individual shared that although they did not feel ready for counselling or treatment that they felt supported by the hands-on work that the Transitional Community Support worker was able to provide. Being able to have someone support them in cleaning and organizing their apartment was making a difference in their overall well-being, even if they were not receiving counselling. The individuals shared that having a place to live that feels like home is important.

Notes from the Transitional Community Support Worker: These are strengths and successes I have pointed out to individuals accessing the program:

1. One individual was accessing the Crisis Line on a daily basis and throughout the program had decreased their usage of the Crisis Line to approximately twice a week. They also started using the local line sometimes as opposed to one out of town.

2. One individual isolates themselves socially and states that they are unable to complete any Activities of Daily Living (ADL) independently. That individual attended two building events and completed laundry independently since being in the program. This individual has also recently identified and agreed to bring in other community agencies for support.

3. A number of tenants identified that an individual with mental health issues has always refused to access any type of mental health support in the past. This individual has now had approximately a 30 minute conversation with the Transitional Community Support Worker and waves to the worker when the worker is at the building. The individual has not accessed support yet, but is building rapport which can sometimes be the hardest part.

Challenges, Learnings & Successes

General Challenges

- Developing mutual understanding of each organization's needs for the pilot and processes to accommodate both (information, documentation, etc.)
- Having to identify & resolve differences in policies between the two participating agencies (i.e. CMHA and MSDSB). This was particularly evident in terms of information sharing and the nature of 'consents'.
- Learning to communicate with each partner organization was determined early on (e.g. meetings for supervision support of employee, supervisors from each organization meetings for regular updates and quarterly meetings with senior management from each organization to review statistics, ensure service clarity and provide clear direction.
- Initial list of "referrals" was very large – more time needed to be spent up-front in determining a manageable caseload.
- Developing rapport with tenants was very difficult and took much longer than anticipated (trust issues, distance, unable to connect)
- Difficulty connecting with tenants who don't have a telephone, or do not return calls.
- Very large geographical area to cover
- Large amount of referrals, not able to provide support to everyone in need

- Most tenants had multiple and or complex issues requiring a lot of time over an extended period.
- Hoarding is a growing issue that requires specialized and long term support – no resources available in Manitoulin / Espanola area
- Transitional Community Support Worker feeling isolated and disconnected from colleagues
- Administrative challenges for TCSW with printing, documentation, entering case notes, etc.
- Pilot temporary on hold due to absence of Transitional Community Support Worker from Nov 22nd to Dec 31st. Pilot resumed with new TCSW on Jan 3rd.
- Speed of the internet in the common rooms makes it difficult to remotely connect to my CMHA desktop. It means that the TCSW was saving a lot of things onto her computer and then emailing them to herself when they are completed in order to have it accessible from whatever computer she choose to use. Sometimes when she went to the main office, she would have to open her laptop to send herself the documents to open them on her desktop to print them. It's was a very long process. Remote Internet connection is difficult to complete time sheets, documents, CRMS minutes, etc.
- Being stationed in the common rooms creates a "fish bowl" effect. Everyone in the building wants to know who is in the room and why they are chatting with this worker.
- Cliques. There are certain groups of people always attending the drop-in hours, that don't necessarily need the support, and it stops other tenants from dropping in as they feel less welcome from the group.
- No peer support offered in the area. Some individuals just need someone to talk to. Recreational programming in the area is for seniors or children, very little else available. Would benefit a number of the individuals that have been involved in the program.

Geographical Challenges

- Huge geography meant that the TCSW spent most of time in transition (between social housing units). This posed challenges in the following areas:
    1. Travel costs
    2. Time & opportunity to document visits (i.e. case notes). Distance between social housing units and time spent travelling meant the worker had to re-think caseloads (i.e. using telephone support when this makes sense to augment on-site visits).
- Traveling distance can make it difficult to give the caseload all that it deserves. Particularly this becomes an issue on Manitoulin Island. There have been time constraints in order to meet the start time of Community Paramedicine Sessions.

Successes

- Paramedicine program
    - opportunity for TCSW to connect with individuals who may not have reached out otherwise
    - opportunity for TCSW to network, be a regular "face"' on-site, build rapport
    - opportunity for tenants to obtain medical assistance and early intervention
    - a tenant in Webbwood with mobility issues was able to access the program with the team visiting his apartment
    - Paramedics to receiving mental health training in April 2017
- A tenant supported by TCSW had a number of complex issues including mental health concerns, addiction, legal (lost custody of 2 children), financial and employment. The tenant has had a

number of positive changes in her life since receiving support and is about to regain custody of her children.

- Some of the buildings have a community feel and this supports the tenants who are too anxious to meet this worker. The tenants who are coming for the drop-in bring back information to others in the building they feel could use it.
- Reaching out to individuals in the building make them feel welcome and sometimes a simple hello will spark a conversation on how they are feeling.
- Being present in the building and having regular times when the worker is present allows individuals to know when you are going to be there. Has brought people around to ask questions.
- Setting boundaries with individuals have created a spark to get them to want to connect with other resources.
- A married couple shared that without the support of previous TCSW advocating on their behalf that they would be in a situation hazardous to their health and wellbeing due to their past apartment.
- Having an experienced TCSW who can work independently and take initiative in this position is critical to the success of the project. I.e. being able to engage "marginalized" individuals on their own terms and in their homes.
- Breaking down traditional barriers between service providers and individuals is key.

Building Rapport – Letting them take the Lead

- Building rapport is critical – the worker could spend 2 or 3 meetings listening to the resident and affirming where they are at. Included here would be to affirm all and any signs of progress in the area of addictions (i.e. harm reduction approach).
- Having cross-sectoral relationships is critical in order to be able to support tenants – included here would be relationships with non-traditional providers (i.e. transgender community; First Nation contacts; human trafficking – people with lived experience who could be mentors). What does 'peer outreach' look like in rural areas?
- The focus for the worker was to provide a comfortable and non-threatening approach – putting priority on 'easy conversations' when first meeting an individual. Letting an individual take the lead as well as recognizing when it makes sense to end the conversation on a good note, even if it is brief.

Complex Challenges

- Supporting tenants who face complex issues that inter-twine to create unstable housing situations (i.e. instances where the symptoms of 'trauma' interfere with the ability of an individual to comply with housing rules/regulations). For example, 'flashbacks' could be so severe as to interfere with a person's ability to work, including their ability to be productive in their work environment. Symptoms such as 'anxiety/panic attacks' might be triggered by certain work environments (i.e. fast food establishments) which would limit the types of jobs a person with anxiety disorder could apply for. Validating the person's experiences and coming from a strengths-based approach overcomes the tendency to view marginalized individuals as 'broken' (i.e. as the sum of their trauma).
- Creating safe spaces and maintaining recovery-oriented principles values the strength, competence of the person accessing services. Being able to connect to non-traditional supports is critical (most often, individuals with lived experience of trauma who can serve as role models

and tangible examples of what's possible). Sometimes, this is the only thing that keeps a person hoping there is light at the end of the tunnel.

Outreach

- Marginalized individuals have very negative experiences with mainstream service providers, feeling discriminated against, re-victimized and treated as though they don't matter. This could mean they are not going to access services in the traditional manner. That's why bringing services to them, where they are at (geographically, personally and emotionally) is so critical. These are individuals who you have to "chase down", who are extremely "distrustful" and who need much more time -- than traditional providers are willing to give – to develop rapport. Logistically, many individuals don't have phones and that is problematic when trying to arrange appointments. Even if they have a phone, they might not have voicemail or they might not answer if they don't know who you are. That's why being able to do outreach and knock on their door to engage in conversation is the most effective way to reach marginalized individuals.
- It was more effective to try to connect with residents on-site rather than making phone calls (people often did not return my call and/or did not have a phone). Seeing a 'face' and having the opportunity to explain the TCSW program in person was much more effective.

Learnings

- Spend additional time in beginning of pilot to understand needs of each organization. Introduce values and processes for mutual understanding.
- Regular on-site visibility at specific buildings improved ability to build rapport, provide brief services and connect with "difficult to reach" tenants.
- Hosting small social events such as a coffee social or arts & crafts can assist with building rapport in a non-stigmatizing way.
- Reduced geographical area with focus on specific sites provided improved opportunity to connect with tenants, reduced travel time and related expenses.
- Important to provide "home-base" for TCSW to feel connected to colleagues and alleviate some administrative challenges. Effective Jan 3/17, CMHA-S/M has been providing an office space in Espanola to touch base with colleagues once per week. The TCSW will have Skype meetings with main site and bi-weekly in person check-ins with supervisor. Having an office in the Espanola CMHA office allows for the worker to have people to talk with and debrief with. It also provides the opportunity to complete paperwork and things without any interruptions.
- May be beneficial to have a TCSW for Manitoulin Island only based on caseload and travel time & expenses.
- Monthly updates on caseload and tenant issues is helpful
- Initially the support by a TCSW was 3-4 months allow, however this timeframe was extended to 6-9 months in order for an opportunity to build rapport and address multiple or complex issues with tenants.
- During planning phase of project, more time needs to be spent on exploring different 'philosophies/practices' around serving "clients".
- How tenants learn about the TCSW program and the process by which tenants are informed they are being referred was established early on in order to avoid confusion for the tenant (i.e. intro letters; explanation of service letter).

- Referral agency letter to resident indicating “reason why” they have been referred to TCSW program was established early on including stipulation that program was voluntary and that TCSW will make 3-4 attempts to contact before closing the file, with provision that if person changes his/her mind, they can contact worker to register for program.
- It is important to schedule time in the office in order to have a faster internet connection and complete necessary paperwork.
- Having a home base at the CMHA office in Espanola really increases the team environment and allows for a chance to debrief when needed.
- Being able to telecommunicate through the internet allows the TCS worker to feel more connected to the team at the main office.
- Being based in the common rooms at the buildings allows us to decrease some of the stigma of accessing the program and helps to offer the individuals a chance to build rapport before accessing the program.
- Having an established presence will allow us to have a socio-recreational environment. This will allow us to develop a community feel by running social groups and events. This will allow for group support and social gatherings in the building.

Potential Considerations

- Discussion that if the Pilot project continued to consider a broader program than Transitional Community Support. Although it is support in housing that some of the individuals need a number also need brief services (i.e. supportive chat, listening, and paperwork support). The position could be remodeled as an in-house mental health support worker (to include housing).
- Evaluation by asking individuals for feedback on the program and how the program could have been improved (April 2017).
- Beneficial to re-look at needs of community. With complexity of issues faced by tenants, longer term case management should also be considered. This benefits 15 – 18 tenants longer term, however once case load is full, it is difficult to assist other tenants.

Future Directions & Implications

The proposed start of the project was anticipated for January 2016, however with organizing the pilot and then recruitment and orientation of staff, there was a delay in service launch (as indicated in the Moving it Forward section).

The need for this project and support to tenants in the DSB buildings in Lacloche, and Manitoulin is evident by the number of areas of support and referrals provided to tenants. The geography of this area created time and resource challenges.

In June 2016, the partners agreed that some shifts in service provision would be needed in order to balance the needs of the community and the work load of the TCSW. The discussion included targeting buildings by comparing stats to previous years; advantage in comparing uptake of services from the perspective of 'Buildings where services offered' vs. "Buildings where no services are offered".

We also agree to move from originally providing services for 3-4 months per individual to extending the timeframes from 6-9 months. This would mean fewer referrals and seeing fewer individuals. However, rural realities and intensity of services required a more focused approach. This trend was being felt in Sudbury as well.

We also discussed the participation in Paramedicine Services which started in August 2016. This was an opportunity to pair up with another service event already happening in designated buildings. It was also seen as a rapport building opportunity with tenants and provide brief services. Discussion about available training for paramedics (15-20) and Mental Health First Aid training (2 days on-site).

This interim evaluation report will act as a summary of the events and services provided in partnership between the Manitoulin-Sudbury DSB and CMHA. As we move into the end of the fiscal year, we have developed a good system for accountability and potential impact to the system and service recipients. Typically a new program will take 2-3 years to mature and gain momentum. We notably have observed this momentum and agreed in principle to extending the program and partnership for an additional fiscal year.

Next steps:
Donna Stewart, Director of Integrated Social Services (DSB) and Patty MacDonald, Director of Operations (CMHA) have met with the NE LHIN to review the pilot and interim report as well as to discuss the possibility of support for the program for an additional year. A final evaluation report will be submitted to the NELHIN with a business case for this unique funding partnership initiative.