



# TORONTO FINAL REPORT

At Home/Chez Soi Project



Mental Health  
Commission  
of Canada

Commission de  
la santé mentale  
du Canada

## AT HOME/CHEZ SOI PROJECT: TORONTO SITE FINAL REPORT

This report was prepared by a team that included Vicky Stergiopoulos, Pat O'Campo, Stephen Hwang, Agnes Gozdzik, Jeyagobi Jeyaratnam, Vachan Misir, Rosane Nisenbaum, Suzanne Zerger, and Maritt Kirst. We also thank Jayne Barker (2008-11), Cameron Keller (2011-12), and Catharine Hume (2012-present), Mental Health Commission of Canada At Home/Chez Soi National Project Leads, the National Research Team, the five site research teams, the Site Coordinators (in particular Faye More, Site Coordinator of the Toronto site), the numerous service and housing providers, and people with lived experience, who have contributed to this project and the research. We would, most especially, like to acknowledge the contributions of At Home/Chez Soi participants, whose willingness to share their lives, experiences, and stories with us were central and essential to the project.

**St. Michael's**  
Inspired Care.  
Inspiring Science.

**CRICH**  
CENTRE FOR RESEARCH ON INNER CITY HEALTH

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# MAIN MESSAGES

## FROM THE TORONTO AT HOME/CHEZ SOI PROJECT

Toronto is Canada's largest and most ethnically diverse city, with the country's largest immigrant population. Nearly 600 participants, of whom about half received Housing First (HF), were followed for up to two years at the Toronto site of the At Home/Chez Soi project, with 80 per cent of all participants returning for a final interview. A network of services for individuals experiencing mental illness and/or homelessness already exists in the city and was available to the other approximately half of participants who received treatment as usual (TAU) during the study period.

Those who received HF were provided with housing and either access to an Assertive Community Treatment (ACT) team if they had high needs or to an Intensive Case Management (ICM) program or a locally designed ethnoracial ICM program for those with moderate needs.

**1 Housing First can be successfully implemented in an ethnically diverse, large urban centre.** Toronto participants were mostly male (68 per cent), single, never married (70 per cent), and aged 35-54 years old (54 per cent). More than half of our participants were from ethnoracial groups (59 per cent) and nearly half were immigrants (46 per cent). Almost all participants were absolutely homeless (93 per cent); the average length of homelessness was  $5.25 \pm 6.19$  years. More than two-thirds of our participants (67 per cent) met criteria for two or more mental illnesses or substance use disorders, of which psychotic disorder (37 per cent) was the most common. In total, 58 per cent of participants reported substance-related problems. More than half had sustained a traumatic brain injury (54 per cent).

**2 Housing First can rapidly reduce homelessness.** At study end, HF participants had been stably housed for 80 per cent of the time compared to 54 per cent among TAU participants. In the last six months of the study, 72 per cent of HF participants were housed all of the time, 16 per cent some of the time, and 12 per cent none of the time; whereas 36 per cent of TAU participants were housed all of the time, 25 per cent some of the time, and 39 per cent none of the time. Average housing quality was similar for HF and TAU residences, and the quality of HF residences was more consistent.

**3 Housing First results in cost savings, particularly for high-needs participants.** On average, the intervention cost \$21,089 per person per year for high-need participants and \$14,731 per person per year for moderate-need participants. Over the two-year study period, every \$10 invested in HF services resulted in an average savings of \$15.05 for high-need participants and \$2.90 for moderate-need participants. The cost savings among high-need participants were driven by reductions in hospitalizations, health provider visits, and emergency department and shelter use. While shelter use decreased among moderate-need participants, there were increased costs for psychiatric hospitalizations.

**4 Housing First can improve community functioning and quality of life.** Both HF and TAU participants improved in observer-rated community functioning and self-reported quality of life over the length of the study. However, HF participants had statistically significant improvements in community functioning compared to TAU participants. Similarly, quality of life improved significantly among moderate needs participants from ethnoracial groups compared to their TAU counterparts.

**5 Many lessons were learned on how to successfully implement and adapt a Housing First program.** Ongoing program evaluation helped identify the barriers and facilitators to implementing HF and what adaptations may be needed to address the unique needs of diverse urban populations. Combining the HF philosophy with an anti-racism/anti-oppression framework showcases how HF can be successfully adapted for this population. Further adaptations of the model may be needed to address the needs of the small group of HF participants who did not achieve stable housing at the Toronto site.

**6 Change is not always measured in numbers.** Qualitative methods, including narrative interviews with a representative sample of participants, revealed participant trajectories into homelessness, experiences with mental illnesses, strategies of coping and resilience, as well as pathways out of homelessness, and the related impact on mental health and service use. Sub-studies helped researchers better understand participants' experiences of discrimination. Narrative interviews revealed that both study groups (HF and TAU) experienced positive and negative changes in their lives, and many participants described housing as a catalyst for making positive life changes. Participants perceived that housing enabled them to experience a sense of control, security, and safety in their lives, which was needed to begin a process of recovery. Sub-studies helped researchers better understand the experience of housing and rehousing among participants, as well as the experiences of landlords working with the project. The contribution of the People with Lived Experience (PWLE) Caucus was another unique element of the study at the Toronto site.

# EXECUTIVE SUMMARY

## FROM THE TORONTO AT HOME/CHEZ SOI PROJECT

Homelessness is an ongoing social and economic problem that affects thousands of Canadians. In Toronto, Canada's most populous city, more than 5,000 individuals are homeless on any given night and in 2008 approximately 28,000 unique individuals used homeless shelters over the course of the year. Housing First (HF) has emerged as an evidence-based practice for meeting the unique needs of this population.

The At Home/Chez Soi research demonstration project was a complex health intervention that explored the Housing First approach to improving the lives of individuals who experience both homelessness and serious mental health problems. The project was funded by Health Canada through the Mental Health Commission of Canada (MHCC), built on existing evidence and knowledge in the field, and applied it to the Canadian context. The At Home/Chez Soi Project took place in five cities across Canada: Moncton, Montréal, Toronto, Winnipeg, and Vancouver. The project aimed to develop evidence on effective services and interventions for people who are homeless and living with mental health problems, and will help inform policy and programming to end homelessness in Canada.

**This report describes findings from the Toronto site of the At Home/Chez Soi project.** Unique contextual and developmental features are also discussed, including an intervention that provides ethnoraical Intensive Case Management (ER-ICM) to better address the needs of individuals from ethnoraical backgrounds who are homeless. Prior to the initiation of the At Home/Chez Soi project, Toronto already had a wide array of services for people who are homeless and/or have a mental illness. The involvement of people with lived experience of homelessness and mental health problems (PWLE) in the planning, development, and execution of the study was another key feature of the Toronto site.

In total, 575 participants were randomized to either a treatment or usual care group at the Toronto site. Prior to randomization, all participants were first stratified to either a "high needs" or "moderate needs" group, based on their disability and their needs for mental health services. Participants

with high needs were randomized to either Housing First with Assertive Community Treatment (HF-ACT) or a treatment as usual (TAU) group. Participants with moderate needs were further stratified by ethnoraical status. Moderate needs participants who were not from ethnoraical groups were randomized to either a Housing First with Intensive Case Management (HF-ICM) or treatment as usual (TAU) group. Ethnoraical moderate needs participants were randomized to Housing First with Ethnoraical Intensive Case Management (HF ER-ICM), HF-ICM or TAU group. The overall follow-up rate was 80 per cent (87 per cent for HF and 73 per cent for TAU).

Our participants were mostly aged between 35 and 54 years old (54 per cent), male (68 per cent), born in Canada (54 per cent), single/never married (70 per cent), and without dependent children (72 per cent). Nearly all participants (95 per cent) were unemployed and a third (28 per cent) reported a monthly income of less

than \$300. There was a high prevalence of substance-related problems (58 per cent), psychotic disorder (37 per cent), and high or moderate suicidality (30 per cent) among participants at study entry. Nearly half (43 per cent) of participants had two or more hospital admissions for a mental illness in any one-year period in the five years before study entry. More than half our participants (54 per cent) had experienced at least one traumatic brain injury and nearly half (49 per cent) did not complete high school. Many participants had experienced victimization in the six months prior to study entry: 32 per cent experienced theft or were threatened with theft, 37 per cent were threatened with physical assault, and 32 per cent were physically assaulted. More than a third (38 per cent) of participants reported having been involved with the criminal justice system in the six months prior to the study entry. About half of participants (51 per cent) reported lack of basic social support and having no one to confide in.

We evaluated the effectiveness of the Housing First interventions over the length of the study by examining several domains, notably housing stability, health and social outcomes, and economic impacts. Of primary importance, housing stability was significantly improved among participants in all HF groups, compared to their TAU counterparts. At study end, HF participants had been stably housed for 80 per cent of the time compared to 54 per cent among TAU participants. In the last six months of the study, 72 per cent of HF participants were housed all of the time, 16 per cent some of the time, and 12 per cent none of the time; whereas 36 per cent of TAU participants were housed all of the time, 25 per cent some of the time, and 39 per cent none of the time. Average housing quality was similar for HF and TAU residences, and the quality of HF residences was more consistent.

We also examined participant-reported quality of life (QoLI-20) and observer-rated community functioning (Multnomah Community Ability Scale [MCAS]). Quality of life and community functioning improved in both HF and TAU groups, and, in some cases, there was no significant difference in the degree of improvement in these groups. However, moderate needs participants from ethnoracial backgrounds in the two HF-ICM teams saw a marginal improvement in quality of life over the span of the study, compared to their TAU counterparts. In the high needs group, community functioning improved in the HF-ACT group compared to the TAU group. In addition, the final visit MCAS scores were significantly higher in the ACT group compared to the TAU group. Similarly, ethnoracial moderate needs participants had significantly higher MCAS scores at the final study visit and saw an improvement in MCAS over the study period, compared to the TAU group.

The economic impact of HF was also studied, considering all costs incurred by society. HF cost \$21,089 per person per year on average for high needs participants, and \$14,731 per person per year for moderate needs participants. Program costs included staff salaries and expenses such as travel, utilities, and rent supplements. HF for high needs participants is more costly mainly because of the higher staff-to-participant ratio. Over the two-year period after study

entry, HF services resulted in average reductions of \$31,747 in service costs for high needs participants and \$4,274 for moderate needs participants. Thus, every \$10 invested in HF resulted in an average savings of \$15.05 for high needs participants and \$2.90 for moderate needs participants. This net savings arises from a combination of decreases in the costs of some services (cost offsets) and increases in the costs of others. For high needs participants, the main cost offsets were psychiatric hospital stays, home and office visits to health or social service providers, and jail or prison stays. For moderate needs participants, the main cost offsets were shelter stays and stays in single room accommodations with support services. For moderate needs participants, cost increases were seen in general hospital stays in psychiatric units.

Qualitative methods were also used to document the inception and planning process in Toronto, both to highlight critical ingredients for successful implementation of HF and to capture participants' stories of recovery.

Key features of the qualitative work included documenting the process through which the diverse team of stakeholders in Toronto planned a complex health intervention that aligned with local needs and interests in the context of a highly politicized service and community environment. Evaluation processes identified successes and challenges at the Toronto site, and helped further our understanding of the barriers and facilitators to implementing HF. Several contextual factors influencing the implementation of the project in Toronto, and subsequent adaptation and innovation, are also identified. This report also highlights key features of the third intervention arm of Toronto's At Home/ Chez Soi project, which combines the Housing First philosophy with an anti-racism/anti-oppression (AR/AO) framework in order to engage and provide support services to clients from racialized groups.

Qualitative methods were also used to further our understanding of participants' trajectories into homelessness, their experiences with mental illnesses, as well as their pathways out of homelessness, and the related impact on their mental health and service use. Narrative

interviews for a representative subsample revealed that participants in both study groups (HF and TAU) experienced positive and negative changes in their lives, and many participants described housing as a catalyst for making positive life changes. Participants perceived that housing enabled them to experience a sense of control, security, and safety in their lives, which was needed to begin a process of recovery. This report highlights positive and negative changes reported by participants over time.

Several salient themes are explored throughout the qualitative work and are supplemented by the findings from a number of sub-studies conducted at the Toronto site. Findings from these studies are highlighted in this report and include strategies for coping and reliance amongst study participants, the experience of housing and rehousing among participants in HF groups, as well as the experiences of landlords working with the project. This report also highlights findings from a participatory evaluation on the People with Lived Experience (PWLE) Caucus at the Toronto site.

Finally, the Toronto site of the At Home/ Chez Soi project achieved extraordinary success in obtaining sustainable funding for the continued delivery of the HF intervention. The Ontario Ministry of Health and Long-term Care, in partnership with the Government of Canada for one year, committed to providing ongoing annualized rent supplements and supports for study participants who received HF. In addition, the Toronto research team at the Centre for Research on Inner City Health at St. Michael's Hospital was successful in obtaining \$1.9 million in peer-reviewed funding from the Canadian Institutes of Health Research (CIHR) to evaluate the longer-term outcomes of HF. This grant will allow the research team to follow study participants for an additional four years beyond the original two-year study period.

For more detailed information on project activities and outcomes, readers are directed to the many reports and other publications available. Together, the findings from the Toronto Site of the At Home/Chez Soi project offer important lessons for research, policy, and program planning, both locally and in other jurisdictions.

# CHAPTER 1

## INTRODUCTION

### Background and Context

Housing First (HF) is a complex intervention that has emerged as an evidence-based approach for meeting the needs of individuals experiencing homelessness and mental illness. Traditionally, treatment options for this population have followed a linear continuum of care approach where participants cannot access permanent housing without first meeting strict requirements on sobriety and acceptance of psychiatric treatment.<sup>1</sup> Instead, HF provides participants with immediate access to permanent independent housing in conjunction with client-centred treatment and mental health support services, and housing is not contingent on acceptance of treatment or demonstration of sobriety.<sup>2-4</sup> Previous research on it from the US has shown that HF can positively affect housing stability and satisfaction, psychiatric symptoms, and participant choice, and is less costly than traditional housing programs.<sup>5-12</sup> No such data have previously been available for Canada.

In 2008, the Federal Government invested \$110 million through a funding agreement between Health Canada and the Mental Health Commission of Canada (MHCC) to support a five-year demonstration project to evaluate what services and systems best help people experiencing serious mental illness and homelessness in the Canadian context. These funds were used to establish At Home/Chez Soi, a pragmatic field trial of the HF program in five cities across Canada (Vancouver, Winnipeg, Toronto, Montréal, and Moncton).

The HF model tested by the At Home/Chez Soi project provides participants with housing, support services and at least one weekly visit by the service team. Participants use no more than 30 per cent of their income towards their rent, with the remainder covered by the rent subsidy. Client choice is emphasized in all aspects of the program, including housing and support services. Support services are provided at two levels of need, with high need participants receiving Assertive Community Treatment (ACT), and those with moderate needs receiving Intensive Case Management (ICM). Because the program emphasizes client choice, the services provided by the ICM/ACT teams will vary and be tailored to the individual, including referrals to other agencies and resources.

**2006**  
**POPULATION IN**  
**TORONTO**  
**= 2.5 MILLION**

**47%** ETHNORACIAL  
ETHNICITY

**> 200 ANCESTRIES**  
**REPRESENTED**

### Toronto Context

Toronto is Canada's most populous and ethnically diverse city: in 2006, the city's population was an estimated 2.5 million,<sup>13</sup> with nearly half (47 per cent) citing ethnoracial ethnicity, representing more than 200 distinct ancestries.<sup>14</sup> Furthermore, half of all Toronto residents are immigrants to Canada, and 81 per cent of new immigrants to Toronto between 2001 and 2006 were from visible minority groups.<sup>15</sup>

Homelessness is an ongoing problem in the city: an excess of 5,000 people are homeless on any given night.<sup>13,16</sup> Of this number, more than three-quarters (79 per cent) live in shelters, eight per cent on the street, six per cent in correctional facilities, four per cent in health care or treatment facilities, and another three per cent in Violence Against Women shelters.<sup>17</sup> In 2008, approximately 28,000 unique individuals used homeless shelters in Toronto over the course of the year.<sup>18</sup>

The diverse makeup of the city is similarly reflected in its homeless population. The City of Toronto has identified ethnoracial and immigrant groups at high risk of homelessness.<sup>19</sup> Among the Toronto homeless population, a recent study of shelter or meal program users reported that almost half (45 per cent) identified as belonging to a non-White ethnic group, most commonly Black (22 per cent), and Aboriginal (nine per cent).<sup>20</sup> About one-third of people experiencing homelessness in Toronto are immigrants to Canada who experience particular barriers to accessing services related to race, language, and social stigma.<sup>21,22</sup>



...a group of PWLE were engaged as part of the ongoing planning, development, and execution of the study, and provided advice and expertise during the study development process, in addition to continuing to advise on all aspects of the project...

As part of the At Home/Chez Soi demonstration project, the Toronto site shared in the project's overall design.<sup>23</sup> However, the context and development of the project in Toronto had several important and sometimes unique elements. First, there is a relatively large array of existing services available for individuals experiencing homelessness in Toronto, including drop-in centres, emergency shelters, meal programs, street outreach services, and supportive and alternative housing. Second, Toronto has a large network of mental health services that serve individuals who are both housed and homeless, including inpatient and outpatient services, case management, ACT, crisis programs, and ethnoracial-focused agencies. Third, the City of Toronto operates the Streets to Homes program, which engages with individuals experiencing homelessness who are living outdoors using a modified HF approach.<sup>24</sup> Fourth, the involvement of People with Lived

Experience (PWLE) of homelessness and mental health problems has been a central element of the At Home project at the Toronto site: a group of PWLE were engaged as part of the ongoing planning, development, and execution of the study, and provided advice and expertise during the study development process, in addition to continuing to advise on all aspects of the project, including service provision and research protocols for the duration of the study. Fifth, the Toronto site developed a unique intervention program that provides ethnoracial Intensive Case Management (ER-ICM) for study participants with moderate needs who belong to a racialized group. Finally, the Toronto site of At Home/Chez Soi was and is being run by an intersectoral partnership to promote integration across the mental health, housing, social services, and research sectors. Figures 10.1 and 10.2 in Appendix A display the Toronto site partnerships and site governance.

# CHAPTER 2

## PROGRAM DESCRIPTIONS

The At Home/Chez Soi study was a randomized controlled trial (RCT) that followed participants for up to 24 months. Prior to randomization, all eligible participants were stratified into two need groups (high needs vs. moderate needs) based on an algorithm that included the level of community functioning (measured by the Multnomah Community Ability Scale [MCAS]), mental disorder diagnosis (based on the Mini International Neuropsychiatric Interview [MINI]), co-morbid substance use conditions, prior hospitalizations, and incarcerations. The detailed algorithm for stratification into need groups is provided in Table 10.1 in Appendix B.

Specific to the Toronto site, moderate needs participants were further stratified by ethnoracial group membership prior to randomization. Participants who did not self-identify as belonging to an ethnoracial group were randomized to either Housing First with Intensive Case Management (HF-ICM) or a Treatment as Usual (TAU) group. Participants who indicated membership in an ethnoracial group were allowed to choose between assignment to the regular ICM intervention or a Housing First with ethnoracial ICM intervention (HF ER-ICM). Choice was allowed as long as there was available space remaining in study groups. As a result, moderate needs ethnoracial participants were assigned to both the regular ICM and ER-ICM intervention groups. Figure 10.3 in Appendix A shows the participant flow through the study.

Participants identified as high needs were randomized to either Housing First with Assertive Community Treatment (HF-ACT) or TAU, regardless of ethnoracial group membership status. Since there was no unique ethnoracial intervention for participants with high needs, both non-ethnoracial and ethnoracial high needs participants randomized to receive treatment were provided services by the same ACT team (Figure 10.3, Appendix A). All teams had training in cultural competency and anti-racism/anti-oppression (AR/AO) principles.

Participants who indicated membership in an ethnoracial group were allowed to choose between assignment to the regular ICM intervention or a Housing First with ethnoracial ICM intervention (HF ER-ICM).

### At Home/Chez Soi: Treatment Groups

The Toronto site had three treatment groups: Housing First with Assertive Community Treatment (HF-ACT), Housing First with Intensive Case Management (HF-ICM) and Housing First with Ethnoracial Intensive Case Management (HF ER-ICM). Table 10.1 in Appendix B summarizes the main features of each treatment group. Services for participants in all treatment groups shared many common elements:

- All participants randomized to the intervention groups received a rental allowance of \$600 per month. The rent allowance was paid directly to the landlord; however, the participants were named on the lease and entitled to all rights and obligations as a tenant under provincial legislation. The study budget also included an allowance for furnishing and moving costs. Housing was mostly provided in scattered site private market apartments.
- Study participants in the intervention groups additionally received support services, which differed depending on their service needs and ethnoracial group membership (see next page, Figure 10.3, and Table 10.1 for details regarding each treatment groups). Services were offered throughout the study, but client participation in treatment for their mental health and addiction problems was voluntary (i.e., tenancy was not tied to participation in treatment).
- Participants were not required to abstain from drugs or alcohol. The only requirements of the intervention group participants were that rental payments from their income were made directly to landlords and that participants met with a project case manager at least once a week.

The only requirements of the intervention group participants were that rental payments from their income were made directly to landlords and that participants met with a project case manager at least once a week.

### **Housing First with Assertive Community Treatment (HF-ACT)**

Participants in the high needs group randomized to the HF group were provided services by an Assertive Community Treatment (ACT) team. The ACT team had a 9:1 participant to staff ratio and were available to participants seven days a week. Overnight crisis coverage was available through Toronto's crisis line services. Participants had access to the entire ACT team, which included psychiatrists and nurses. The ACT team provided all of the relevant services, including case management, initial/ongoing assessment, psychiatric services, employment and housing assistance, family support and education, substance use services, and other services and support to allow the individual to live successfully in the community.

### **Housing First with Intensive Case Management (HF-ICM)**

Participants randomized to the HF-ICM program were connected to a case manager who worked with them to develop a service plan. The HF-ICM program focused on supporting housing stability and consumer-driven recovery goals. Case managers brokered the services needed by participants and accompanied participants to appointments. The HF-ICM team in Toronto had access to a psychiatrist, half a day per week.

### **Housing First with Ethnoracial Intensive Case Management (HF ER-ICM)**

Similarly to the HF-ICM participants, participants in the HF ER-ICM program were connected to a case manager who worked with them to help develop a service plan. The program additionally had a focus on providing services and programs oriented towards the ethnoracial population. Case managers took a more holistic approach to mental health care, recognizing spiritual, emotional, mental, physical, social, economic, cultural, linguistic, and broader environmental aspects of life including social determinants of health. A main goal of the model was to help participants address experiences of racism and oppression and build support networks, including relationships with family and friends. Some of the additional programs that were available to HF ER-ICM participants included integrative peer support, skills building, social and recreational activities, support groups, alternative and complementary therapies (including art and music therapy), creative expressions, community kitchen, and individual and community outreach. The HF ER-ICM team had access to a psychiatrist half a day per week.

### **Treatment as Usual Group (TAU)**

Participants randomized to the TAU group were able to access a variety of pre-existing community programs and services in the City of Toronto. A range of programs and services exist that serve the homeless population including drop-in centres, emergency shelters, meal programs, street outreach services, supportive and alternative housing. In addition, several mental health services are available to both homeless and housed individuals, including inpatient and outpatient services, case management, Assertive Community Treatment (as above), court support services, crisis programs, and ethnoracially focused agencies. Finally, Streets to Homes, a program directly operated by the City of Toronto, engages the street homeless population and employs a modified Housing First approach.<sup>24</sup> The study actively provided TAU participants with information about these existing services.

# CHAPTER 3

## SAMPLE CHARACTERISTICS

Between October 2009 and June 2011, a total of 1,342 referrals were received to the Toronto site of At Home/Chez Soi. The largest proportion of referrals was received from shelter services (39 per cent), but drop-in centres (14 per cent), outreach programs (12 per cent), hospitals (11 per cent), and mental health services (seven per cent) were also key sources of recruitment. A total of 726 (54 per cent) referrals passed the initial review for eligibility and underwent further screening.

A total of 575 individuals (43 per cent of all referrals) met all eligibility requirements, provided informed consent, and completed screening and baseline interviews. Of this number, 197 met criteria for the high needs group and 378 for the moderate needs group. Randomization resulted in the assignment of 301 individuals to one of the three Housing First (HF) groups and 274 individuals to respective treatment as usual (TAU) comparison groups. Among the HF groups, 97 were assigned to the HF with Assertive Community Treatment (ACT) group, 102 to the HF with Intensive Case Management (ICM) group and 102 to the HF with ethnoracial Intensive Case Management (ER-ICM) group (Figure 3.1).

### Participant Demographics

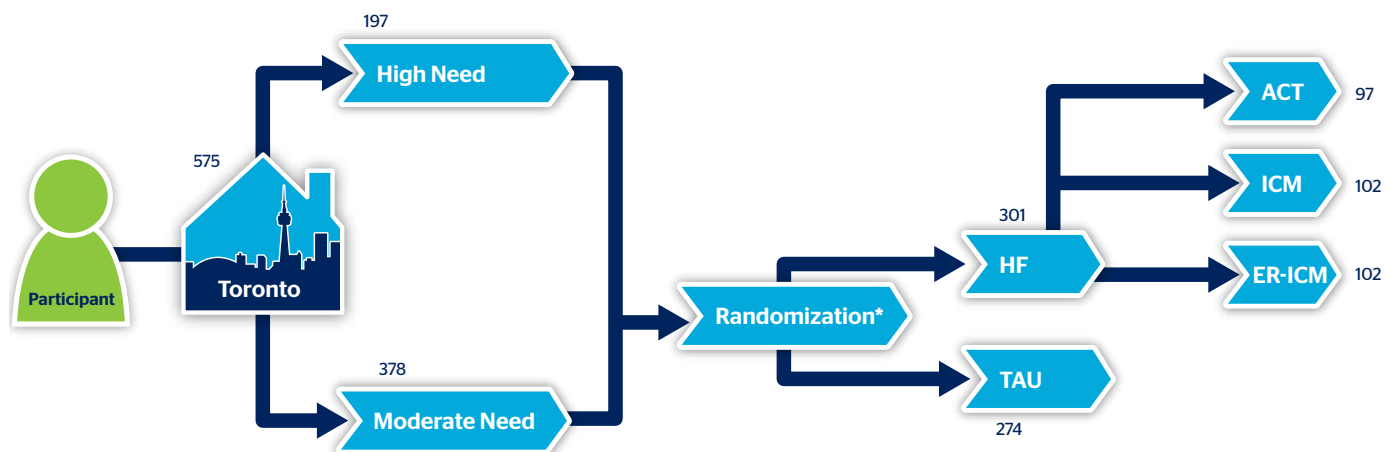
Table 3.1 summarizes the characteristics of participants at study entry for the overall sample by need level. More than half of our participants were aged 35 to 54 (54 per cent), with roughly one-third aged 34 or younger (36 per cent), while the remaining 10 per cent were aged 55 years or older. While males are more numerous in the homeless population generally, we strove to recruit a higher sample of females to learn more about this under-studied

group. As a result, males made up 68 per cent and females 30 per cent of study participants. More than half our sample (54 per cent) named Canada as their country of birth. More than half of our sample reported non-Aboriginal non-white ethnicity (59 per cent). Only four per cent of our study participants were married or living common-law, with 28 per cent reported having one or more children. A small, but important percentage (four per cent) of participants were veterans, having reported wartime service for Canada or an allied country. There are many indications that participants have multiple challenges in their lives that have contributed to their disadvantaged status. For example, nearly half (49 per cent) did not complete high school, and a third (28 per cent) reported that their prior month income was less than \$300. While almost all (95 per cent) were unemployed at the time of study entry, more than two-thirds (68 per cent) have worked steadily in the past, which suggests a reasonable potential for re-employment after stabilization in housing.

### Homelessness History

Most study participants were recruited from shelters or the streets. An overwhelming number indicated that they were absolutely homeless (93 per cent) while seven per cent lived in precarious living situations (for definitions see Table 10.2 in Appendix B or <http://bmjopen.bmj.com/content/1/2/e000323.full>). One in four (24 per cent) first became homeless in the year prior to entering the study. The longest single past period of homelessness reported by participants is about 360 months, and the typical total time homeless in participants' lifetimes is nearly 35 months (2.92 years). Participants report a typical age of first homelessness of around 31 years.

Figure 3.1 How Participants Were Assigned



## Past and Current Personal, Health, and Social Circumstances

At entry, participants reported symptoms consistent with the presence of the following mental illnesses: 37 per cent psychotic disorder, 65 per cent non-psychotic disorder, and 58 per cent substance-related problems. Nearly half (43 per cent) of participants had two or more hospital admissions for a mental illness in any one-year period in the five years before study entry, and five per cent of participants reported having been hospitalized for a mental illness at least once for more than six months in that time period. Additionally, more than half (54 per cent) reported a traumatic brain injury. Nearly a third (32 per cent) reported having a learning problem or disability. The mean score on the Adverse Childhood Experiences scale among our participants was 4.1 (out of a maximum score of 10), indicating a very high level of exposure to child abuse and/or neglect before the age of 18.

More than a third (38 per cent) of our participants reported having been involved with the criminal justice system in the six months prior to the study, having been arrested one or more times, been incarcerated, or served probation. Many participants reported experiencing victimization in the six months prior to study entry: 32 per cent were robbed or threatened to be robbed, 37 per cent were threatened with physical assault, and 32 per cent were physically assaulted. Participants lacked basic social support – around half reported having no one to confide in. General distress levels were also high, with 30 per cent reporting symptoms consistent with moderate to high suicide risk (standard safety and referral processes were followed if a participant was deemed at immediate risk of suicide).

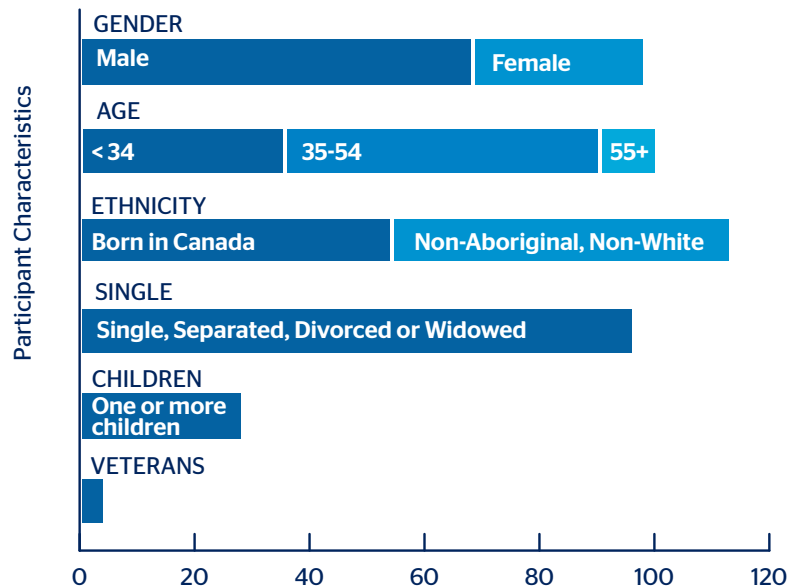


Table 3.1 Participant Demographic Characteristics – Toronto\*

	TOTAL SAMPLE N=575 %	HN N=197 %	MN N=378 %
<b>AGE GROUPS</b>			
34 or younger	36	38	35
35-54	54	54	53
55 or older	10	8	12
<b>GENDER</b>			
Male	68	73	66
Female	30	26	31
Other	2	1	2
<b>COUNTRY OF BIRTH</b>			
Canada	54	61	51
Other	46	39	49
<b>ETHNIC STATUS<sup>^</sup></b>			
Aboriginal	5	5	5
Other ethnocultural	59	51	63
<b>MARITAL STATUS</b>			
Single, never married	70	74	68
Married or common-law	4	4	4
Other	26	22	28
<b>PARENT STATUS</b>			
Any children	28	24	30
<b>EDUCATION</b>			
Less than high school	49	52	47
High school	19	19	19
Any post-secondary	32	29	34
<b>PRIOR MILITARY SERVICE</b> (For Canada or an ally)	4	3	4
<b>Prior month income</b> less than \$300	28	29	27
<b>Prior employment</b> (Worked continuously at least one year in the past)	68	66	69
<b>Currently unemployed</b>	95	97	94

\* all information was reported by participants

<sup>^</sup> these values will not reflect proportions in the general homeless population due to deliberate oversampling of ethnocultural groups

Table 3.2 Past and Current Personal, Health, and Social Circumstances – Toronto\*

	TOTAL SAMPLE N=575 %	ACT N=197 %	ICM N=378 %
Need level (determined by study screening)			
High need	34	100	0
Moderate need	66	0	100
Adverse Childhood Experiences (ACE)			
Mean score (out of a possible 10)	4.1	3.9	4.2
COGNITIVE IMPAIRMENT			
Received extra help with learning in school	35	38	34
Has a learning problem or disability	32	35	31
DIAGNOSIS AT ENROLMENT			
Psychotic disorder	37	59	26
Non-psychotic disorder	65	43	77
Substance-related problems	58	61	57
SUICIDE RISK AT ENROLMENT			
Moderate or high	30	24	33
COMMUNITY FUNCTIONING AT ENROLMENT (rated by interviewers)			
Average MCAS score <sup>‡</sup> (lowest and highest scores)	61 (33 - 79)	55 (33 - 62)	65 (46 - 79)
HOSPITALIZED FOR A MENTAL ILLNESS <sup>§</sup> (for more than six months at any time in the past five years)	5	12	1
HOSPITALIZED FOR A MENTAL ILLNESS <sup>§</sup> (two or more times in any one year in the past five years)	43	76	26
SERIOUS PHYSICAL HEALTH CONDITIONS			
Asthma	20	20	21
Chronic bronchitis/emphysema	11	12	11
Hepatitis C	13	12	13
Hepatitis B	2	2	2
HIV/AIDS	1	2	1
Epilepsy/seizures	9	15	6
Heart disease	5	6	4
Diabetes	10	12	9
Cancer	2	3	2
TRAUMATIC BRAIN/HEAD INJURY			
Knocked unconscious one or more times	54	54	54
JUSTICE SYSTEM INVOLVEMENT (arrested > once, incarcerated or served probation in prior 6 months)	38	49	32
JUSTICE SYSTEM INVOLVEMENT TYPES			
Detained by police	25	42	17
Held in police cell 24 hours or less	19	27	15
Arrested	29	39	25
Court appearance	34	43	29
Attended a justice service program	15	22	12
VICTIMIZATION			
Theft or threatened theft	32	39	29
Threatened with physical assault	37	36	37
Physically assaulted	32	36	30
LACK OF SOCIAL SUPPORT			
Lacking a close confidante	51	46	53

\* all information was reported by participants except where noted

<sup>‡</sup> See <http://bmjopen.bmj.com/content/1/2/e000323.full> for definitions of high and moderate need

<sup>‡</sup> Multnomah Community Ability Scale – higher scores indicate better functioning; a score of 62 and below represents moderate to high disability or moderate to poor functioning; items include daily living independence, money management, coping with illness, and social effectiveness

<sup>§</sup> self-report of psychotic illnesses and related hospitalizations are likely to be under-estimates due to the nature of the illness

# CHAPTER 4

## HOUSING OUTCOMES

Housing stability was the key outcome of the At Home/Chez Soi project. Participants were assessed every three months for their residential history. Here we present results on the proportion of time spent stably housed throughout the study period.

At study end, HF participants across all three groups had been stably housed for 80 per cent of the time compared to 54 per cent among TAU participants. In the last six months of the study, 72 per cent of HF participants were housed all of the time, 16 per cent some of the time, and 12 per cent none of the time; whereas 36 per cent of TAU participants were housed all of the time, 25 per cent some of the time, and 39 per cent none of the time.

Figure 4.1 shows the combined results from the Intensive Case Management (ICM) and Assertive Community Treatment (ACT) groups in comparison to their combined treatment as usual (TAU) groups. Clearly the intervention had a rapid and substantial effect on housing stability over the study period.

Figures 4.2, 4.3, and 4.4 show these same results by randomization group at the Toronto site. Although Housing First (HF) was able to rapidly improve stable housing among all three groups, the high needs HF participants (Figure 4.4) saw the largest overall improvement in housing stability in comparison to their corresponding TAU group.

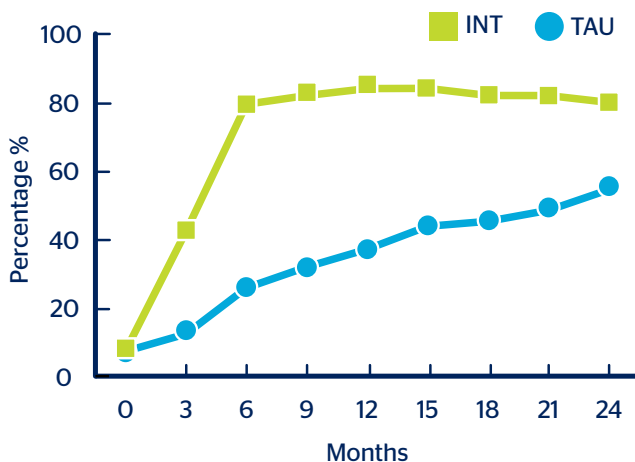


Figure 4.1 Days Stably Housed (all HF vs TAU)

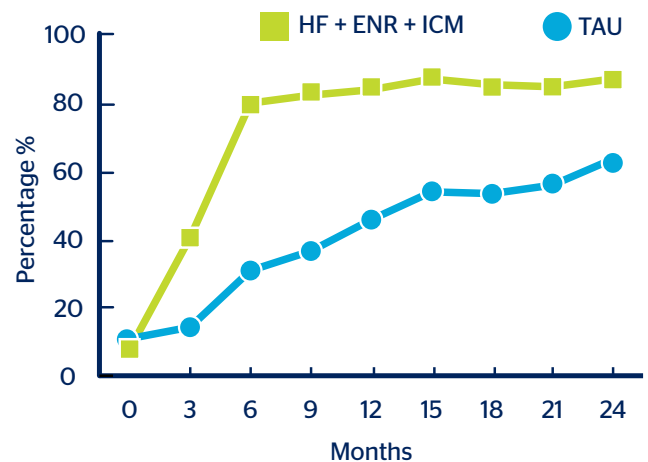


Figure 4.2 Days Stably Housed (MN, Ethnoracial)

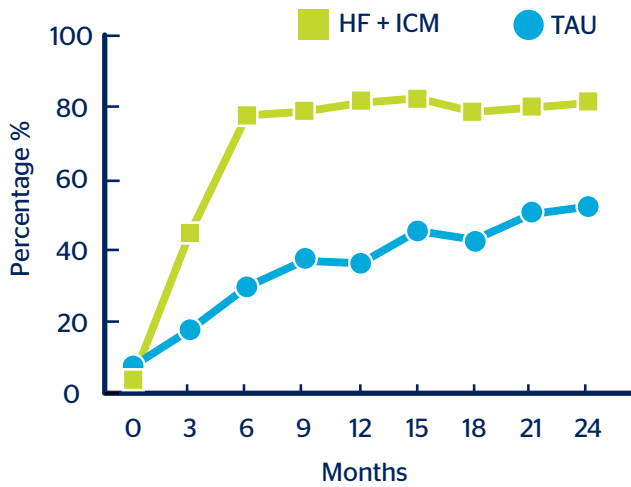


Figure 4.3 Days Stably Housed (MN, Non-ethnoracial)

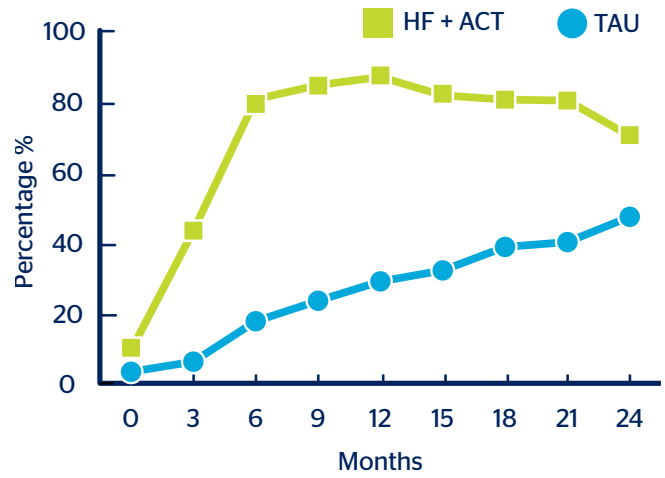


Figure 4.4 Days Stably Housed (High needs)

## Housing quality

Housing quality (including quality of the housing unit, the building, and the neighbourhood) was measured using standard ratings by field research teams in a random sample of participants. Housing assessments were made for HF participants who were housed through the At Home program, and for TAU participants who were able to obtain housing on their own or using other programs and services. For individuals who were housed for at least two months over the study period, housing quality (unit and building) was similar for HF participants and TAU participants, and the quality of HF residences was much more consistent than those of TAU.



# CHAPTER 5

## SERVICE USE AND COST OUTCOMES

### Service Use

#### Health Care Use

Participants were asked every six months to report on their use of health care services, including emergency department visits, outpatient hospital visits, and visits to family physicians and other service providers. This section provides descriptive results for some of these key self-reported outcome variables, which will be further examined with administrative data from government and other agencies in the near future.

Over the course of the study, participants in both the treatment as usual (TAU) and Housing First (HF) groups saw a reduction in their use of both health service providers, which includes family physicians and medical specialists, including psychiatrists, mental health workers such as case managers, and other service providers and outpatient visits to hospitals. Figures 5.1 and 5.2 show results for all HF participants combined (high needs and moderate needs), compared to all TAU participants. HF participants had a more rapid decline in service use, particularly in the earlier part of the study, compared to TAU participants.

An overall reduction over the course of the study was also seen in emergency department visits in both HF and TAU participants. However, the degree of reduction was much sharper among HF participants, particularly in the first six months of the study (Figure 5.2).

#### Justice System Use

Although police contacts remained fairly constant throughout the study (Figure 5.4), there was an overall trend for reductions in arrests during the study period, with greater reductions observed in the HF participants compared to their TAU counterparts (Figure 5.5).

When participants at the Toronto site were examined by need level, those in the high needs group had more frequent contact with the justice system before study entry. More than a third of high needs participants (42 per cent) had been detained by police in the year prior to baseline, and 39 per cent had been arrested. Justice system contacts were lower among moderate needs participants, with 17 per cent reporting being detained by police and 25 per cent reporting being arrested in the year prior to baseline.

An effect of the HF intervention on justice system contacts was observed in the high needs group in Toronto. High needs HF participants saw a substantial overall reduction in arrests, whereas arrest rates remained consistently high among high needs TAU participants.

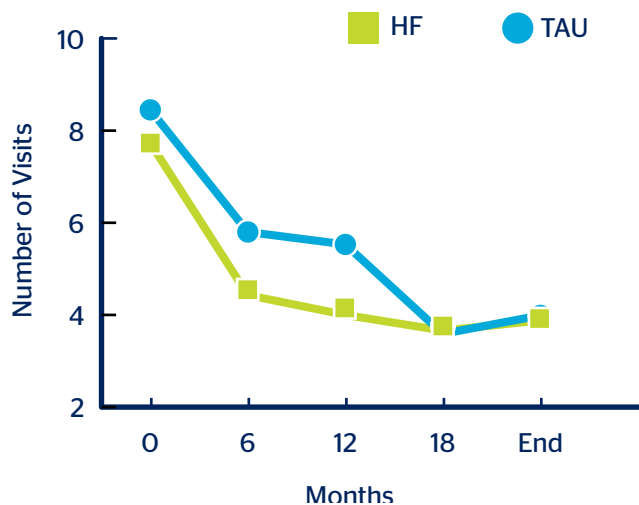


Figure 5.1 Health Service Provider Visits

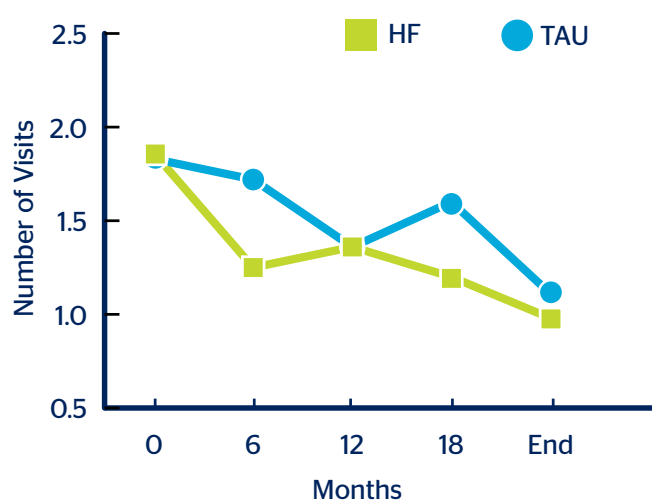


Figure 5.2 Emergency Department Visits

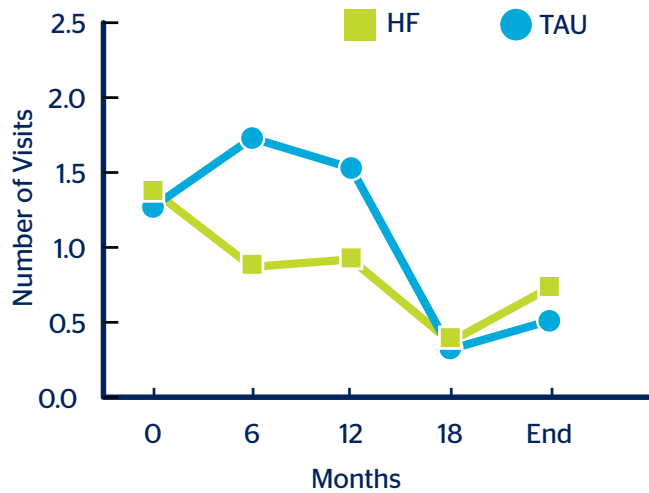


Figure 5.3 Outpatient Visits

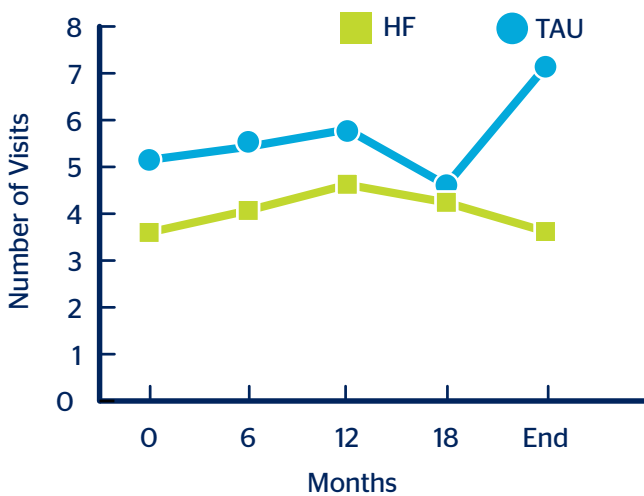


Figure 5.4 Arrests by Police

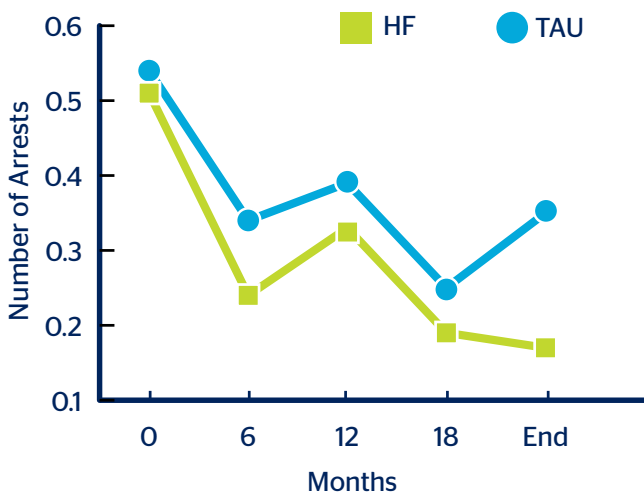


Figure 5.5 Police Contacts

## Costs

The economic impact of HF was also studied, considering all monetary costs incurred by society. In Toronto, HF costs \$21,089 per person per year on average for high needs participants, and \$14,731 per person per year for moderate needs participants. Program costs included staff salaries and expenses such as travel, utilities, and rent supplements. HF for high needs participants is more costly mainly because of the higher staff-to-participant ratio. Over the two-year period after study entry, HF services resulted in average reductions of \$31,747 in service costs for high needs participants and \$4,274 for moderate needs participants. Thus, every \$10 invested in HF resulted in an average savings of \$15.05 for high needs participants and \$2.90 for moderate needs participants. This net savings arises from a combination of decreases in the costs of some services (cost offsets), and increases in the costs of others. For high needs participants, the main cost offsets were psychiatric hospital stays, home and office visits to health or social service providers, and jail or prison stays (Table 5.1). For moderate needs participants, the main cost offsets were shelter stays and stays in single room accommodations with support services (Table 5.2). For moderate needs participants, cost increases were seen in general hospital stays in psychiatric units.

Table 5.1 Main Cost Offsets and Increases for the High Needs Groups

Hospital (Psychiatric)	\$(10,427)
Office visits (non-study)	\$(9,204)
Home visits (non-study)	\$(8,172)
Emergency shelter	\$(3,321)
Day centre	\$(1,615)
Jail/prison	\$(1,175)
Court appearances	\$1,053
Hospital (Physical)	\$7,148

Table 5.2 Main Cost Offsets and Increases for the Moderate Needs Groups

Emergency shelter	\$(2,770)
Court appearances	\$(1,891)
Office visits (non-study)	\$2,322

## Summary

We observed changes in reported service use patterns among HF participants throughout the length of the study, but these patterns varied not only by the treatment group, but also by type of service and by need group. Overall, these service use patterns demonstrate a trend towards a reduction in costly services among participants in the HF program and greater use of more appropriate community-based services. This effect is particularly notable among high needs individuals, who had high levels of health care and justice system use prior to study entry. For the high needs group in Toronto, reductions in service costs fully offset the costs of the HF intervention and even generated a significant cost savings.

# CHAPTER 6

## SOCIAL AND HEALTH OUTCOMES

### Community Functioning, Quality of Life, Mental Health, and Substance Use Outcomes

People who are homeless, particularly those who experience street homelessness or rely on shelters, often focus on meeting their basic needs for food and shelter and avoiding being victimized. Physical, mental, and substance use problems are often neglected and exacerbated. The average participant at the Toronto site had been homeless during their lifetime for about five years prior to enrolling in the At Home/Chez Soi study, with many reporting longer periods of homelessness throughout their lives. We wanted to examine how our participants fared with respect to overall community functioning, quality of life, mental, and substance use outcomes throughout the study to better understand the process of recovery and improvement in these domains.

#### Community Functioning

The At Home/Chez Soi project used the Multnomah Community Ability Scale (MCAS) as an assessment tool for measuring community functioning. This 17-item scale covers mental and physical health, ability to cope with illness, social skills, and problem behaviours. Higher MCAS scores are indicative of better community functioning. Unlike most of the other instruments in the study, which rely on participants' self-reports, the MCAS assessment is administered by the research interviewer. As a result, the MCAS allows us to compare the participant's own perspective with the assessment of an independent evaluator. Below, we report on the MCAS findings for the Toronto site by randomization group.

##### High needs participants

At the final study interview, MCAS scores were statistically significantly higher in the treatment (HF-ACT) compared to the TAU group ( $p=0.003$ )<sup>1</sup> (Figure 6.1). That means that the difference is large enough such that it is very unlikely to be just a chance occurrence. In addition, there was a marginally significant difference between the two groups over the intervention period ( $p=0.04$ ), again, not likely due to chance alone.

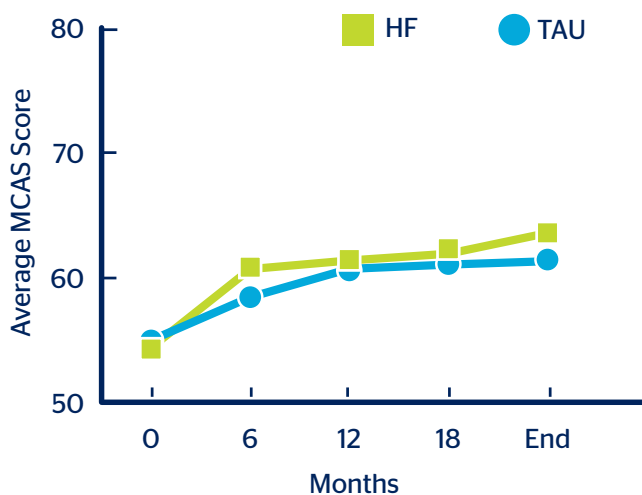


Figure 6.1 Community Functioning (High Needs)

##### Moderate needs non-ethnoracial participants

There were no significant differences in MCAS scores between treatment (HF-ICM) and TAU groups at the final interview ( $p=0.63$ ), as well as no differences between the two groups over the length of the follow-up period ( $p=0.60$ ) (Figure 6.2).

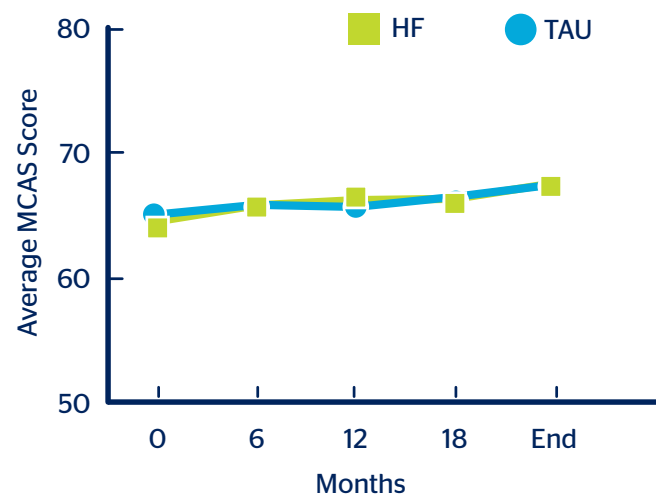


Figure 6.2 Community Functioning (Moderate Needs, Non-Ethnoracial)

<sup>1</sup> In scientific terminology,  $p$  (probability) values measure how likely the differences we observe between groups could have arisen by chance alone. In our study, differences are considered statistically significant if the  $p$ -value was smaller than four percent (0.04). This means that there was a four percent or less chance these results would have arisen by chance alone.

### Moderate needs ethnoracial participants

There was a significant difference between ethnoracial participants randomized to treatment (HF-ICM and HF ER-ICM) compared to TAU in MCAS scores at the final visit ( $p < 0.001$ ) and over the entire study follow-up period ( $p = 0.01$ ). Treatment resulted in significantly better community functioning (Figure 6.3).

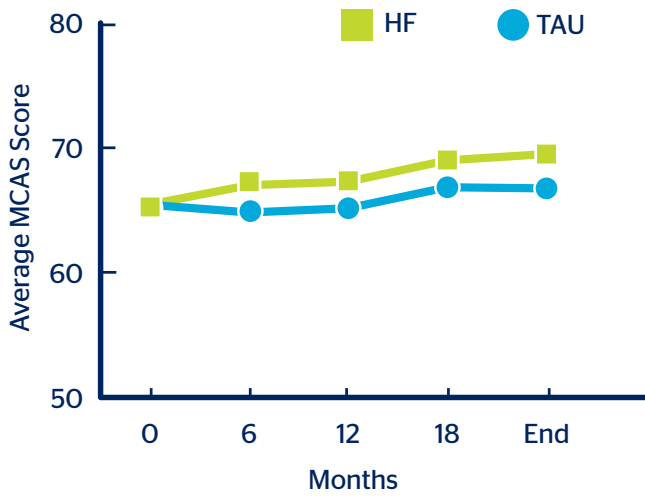


Figure 6.3 Community Functioning (Moderate Needs Ethnorracial)

### Quality of Life

We measured participants' feelings about their quality of life using the Quality of Life Index (QOLI-20), which asks about satisfaction with family relationships, finances, leisure, living situation, and safety. Higher QOLI-20 scores are indicative of better quality of life. In the section below, we examine how the quality of life differed between HF and TAU participants at the study end point and over the course of the study in each of the three randomization groups.

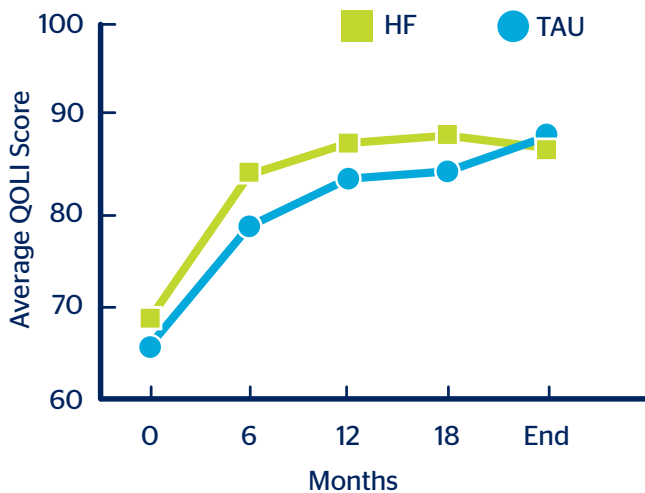


Figure 6.4 Quality of Life (High Needs)

### High needs participants

Among high needs participants, quality of life improved for both treatment and TAU groups over the course of the study (Figure 6.4). At the final study interview, there were no significant differences in the quality of life between Housing First with ACT (HF-ACT) and treatment as usual (TAU) ( $p = 0.72$ ) participants. In addition, quality of life did not differ between the two treatment groups over the entire follow-up period ( $p = 0.94$ ).

### Moderate needs non-ethnorracial participants

There were also no significant differences in the quality of life between Housing First with ICM (HF-ICM) and treatment as usual (TAU) ( $p = 0.26$ ) participants at the final study interview, nor during the entire follow-up period ( $p = 0.97$ ) (Figure 6.5).

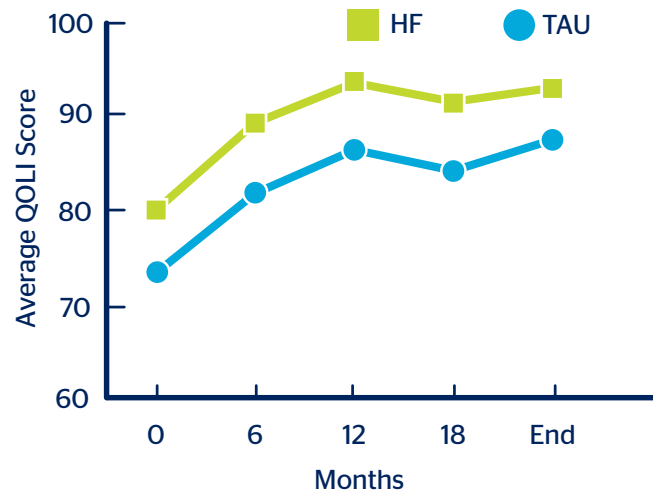


Figure 6.5 Quality of Life (Moderate Needs Non-Ethnorracial)

### Moderate needs ethnorracial participants

Although there were no significant differences in the quality of life between moderate needs ethnorracial HF and TAU participants ( $p = 0.72$ ) at the final study interview, there was a marginally significant difference between the two treatment groups over the entire follow-up period ( $p = 0.04$ ) (Figure 6.6).

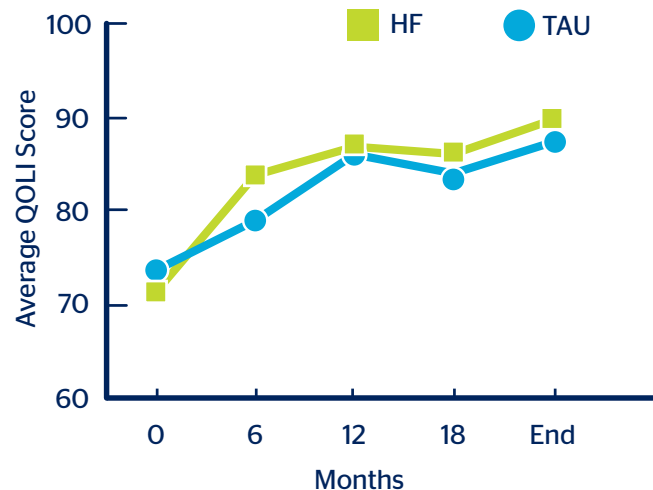


Figure 6.6 Quality of Life (Moderate Needs Ethnorracial)

## Mental Health and Substance Use-Related Outcomes

We examined several health and substance use-related outcomes as part of the At Home/Chez Soi project to see how a HF program may have affected these domains. Below we report briefly on some of the key patterns in these domains at the Toronto site.

### Symptoms of Mental Illness

We used the Colorado Symptom Index (CSI), a scale developed and validated for people experiencing homelessness, to examine symptoms of mental illness throughout the study. Questions on the CSI ask participants to report on how often they experienced depression, anxiety, strange behaviour, and poor concentration over the prior month. Participants were asked to provide this information every six months.

Participants in both the HF and TAU groups saw a substantial reduction in mental health symptoms over the duration of the study. However, the difference in the extent of the improvement in mental health symptoms appears quite similar between the groups, suggesting that participants in the HF group did not have greater improvements in symptoms compared to those in the TAU group.

### Substance Use Problems

To measure substance use problems, we used the short version of the Global Assessment of Individual Needs – Substance Problems Scale (GAIN-SPS). The GAIN-SPS asks people how recently they experienced problems like withdrawal, spending a lot of time finding or using substances, or getting into trouble because they were intoxicated.

Over the study period, we observed a reduction in the number of problems associated with substance use among HF participants. However, there was no evidence that this reduction in substance use was greater among HF participants than in the usual care group. This suggests that housing, in this case, did not necessarily hasten improvements in substance use over time. Another reason may be that when participants were enrolled, they were at a point of crisis in their lives and were bound to get better with time, independent of whether they received housing (or what statisticians call "regression to the mean").

# CHAPTER 7

## CONSUMER EXPERIENCE AND TORONTO-BASED SUB-STUDIES

This chapter summarizes the purpose, methods, and key findings from the consumer narrative interviews at the Toronto site, as well as findings of selected sub-studies that were conducted only at the Toronto site of the At Home project. Findings from additional sub-studies are included in Appendix C.

Many participants described housing as a catalyst for making positive life changes. It enabled individuals to experience hope, a sense of control, security, and safety in their lives, which were needed to begin a process of recovery.

### Consumer Experience: Narrative Interviews of Toronto Site Participants

**Purpose:** To understand early trajectories into homelessness and experiences of mental health issues, as well as pathways out of homelessness and related impact on mental health and service use.

**Methods:** We conducted in-depth narrative interviews with 60 At Home/Chez Soi project participants in Toronto. These interviews gave participants the opportunity to tell their stories and discuss their lived experience. Participants took part in a baseline interview approximately one month after their study entry in the project, and these same participants were followed up to participate in another in-depth interview about their experiences in the project 18 months after baseline.

**Key Findings:** While participant's baseline experiences are reported elsewhere, the following key findings were reported after 18 months of study participation:

- Both study groups, Housing First (HF) and Treatment as Usual (TAU), experienced positive and negative changes in their lives, and both groups spoke about the benefits and challenges of becoming housed after experiencing a period of homelessness. The fact that a number of people in the TAU group found housing independently over the course of the 18 months, and accessed services that were not unlike those provided to HF participants, may account for these similarities across groups. It appears that more HF participants experienced positive life paths than those in the TAU group.
- Many participants described housing as a catalyst for making positive life changes. It enabled individuals to experience hope, a sense of control, security, and safety in their lives, which were needed to begin a process of recovery.
- While many participants were making positive strides toward family reconnection, establishment of new relationships, and community integration, several discussed an increased sense of isolation as they adjusted to their new housing situations, which resulted in setbacks to their recovery.
- Support from a variety of mental and physical health services was described by numerous participants as instrumental to moving forward in recovery. Furthermore, the quality of the client-provider relationship in the context of service utilization was viewed as key to making positive changes across life areas. However, despite improved access to services, many struggled to engage in work and education. Several of these participants reported continued struggles with discrimination related to race/ethnicity, sexual orientation, and mental health issues. Another key finding relates to financial struggles experienced by participants in this study. Although those who were new to the Ontario Disability Support Program (ODSP) were grateful for the increase in finances as compared to no income at all or monies received through Ontario Works (OW), most found these supports insufficient for reaching their goals.
- Overall, for those participants who were doing well and experiencing positive changes over time, key interrelated factors facilitating these changes emerged, including: housing, social support, supports from the health and mental health system, as well as the quality of provider-client relationships, and improved self-efficacy. However, none of these factors alone appeared to be linked to positive changes; combinations of these factors had the greatest impact.

## Toronto-Based Sub-Studies

The Toronto research team conducted a number of sub-studies that were specific to Toronto and designed to complement the overall design of the national At Home study. These Toronto-based sub-studies fell into three major categories: Implementation and Fidelity studies, Discrimination studies, and Physical Health and Primary Care studies. The purpose, methods, and key findings of each sub-study are summarized below. All participants gave informed consent to participate in these sub-studies, which were also approved by the Research Ethics Board of St. Michael's Hospital.

### Implementation and Fidelity Studies

#### IMPLEMENTATION EVALUATIONS

**Purpose:** Two phases of implementation evaluations were conducted to: examine developmental issues including challenges and strengths of implementation, adaptations, and innovations; understand key ingredients to the Housing First model and our unique "third arm" intervention; and, document stakeholder perspectives, including the experiences of landlords, with the program.

**Methods:** We documented the implementation of the project in two phases: 1) an early phase that captured the events from 2009 to 2011, and 2) a latter phase that captured the events from 2011 to 2012. During the early implementation evaluation, 66 participants took part in nine key informant interviews and nine focus groups. The latter implementation evaluation included 28 participants who took part in nine key informant interviews and four focus groups.

**Key Findings:** Several contextual factors influencing project implementation, and subsequent adaptation and innovation, were identified. Themes identified were related to housing choice, availability, and affordability of housing in Toronto, participant recruitment, serving the complex needs of participants, support services caseloads, strong leadership, adapting to changes in the policy landscape, and the ethnoracial diversity of Toronto's population.

Several innovations and adaptations that occurred at the Toronto site in response to our unique service context included:

- The recruitment approach, which was credited with maintaining existing service relationships for participants within the context of a rich service environment, thereby improving community "buy-in" and enhancing supports available to participants.
- The Toronto People with Lived Experience (PWLE) Consumer Caucus helped ground the project in the lived experience of participants, enhanced project capacity to advocate for resources, and led to adaptations in housing and support services delivery (see separate PWLE study on this page).
- On-site psychiatrist and primary care, and the availability of an ad hoc clinical support team to discuss challenges in service provision, enhanced team capacity to address participants' complex health needs.

### PEOPLE WITH LIVED EXPERIENCE (PWLE) CAUCUS

**Purpose:** To assess lessons learned from the PWLE Caucus about the inclusion of consumers in research and service delivery.

**Methods:** This study included review of 42 Caucus-related documents submitted by members and key stakeholders, 11 individual interviews (30-60 minutes), and three focus groups. Caucus members were included on the study team.

#### Key Findings:

- Findings revealed a complex story of Caucus engagement: facing time constraints and given little direction, the Caucus developed through a tumultuous process related to both internal and external barriers to meaningful inclusion. Despite the challenges, the Caucus contributed meaningfully to various aspects of the At Home/Chez Soi project. It is possible to successfully integrate psychiatric consumers with experience of homelessness in many aspects of research and service planning.
- Suggestions for future project-leaders hoping to engage consumers include: early involvement, purposeful selection of members, clear communication of roles and responsibilities, a consumer coordinating group, and space for critical dialogue throughout the process. Lessons learned can inform the inclusion of consumers in similar endeavors in other jurisdictions.

### HOUSING DELAYS AND RELOCATIONS

**Purpose:** To assess factors contributing to undue delays in housing access and/or to multiple requests for relocations after initial housing placement in the HF model.

**Methods:** The sample recruited for this study totaled 48, including 25 consumers and 23 staff. Staff included 18 service providers from the three service teams and five housing workers, including team managers. Consumers were selected and recruited from those who obtained housing after four months (n=10) or one year (n=5), and from those who had made one or more relocation requests (n=10). Semi-structured interviews lasting approximately one hour were conducted with the 25 consumers, three service team managers, and two housing team managers. Four focus groups were held with a total of 15 service providers and one with three housing workers.

#### Key Findings:

- Three major factors influenced delayed housing placement and relocation requests from the perspectives of clients, service providers/case managers, and housing placement workers. These included: 1) the effectiveness of communication and collaboration among consumers and service providers; 2) consumer-driven preferences and ambivalence; and, 3) provider prioritization of consumer choice over immediate housing access. The role of choice strongly affected the timing of housing placements in several ways, all of which these three parties described in terms of recovery.
- Two strategies were identified as supporting the housing process – targeted communications and consumer engagement in housing searches.

## INTERIM HOUSING

**Purpose:** To understand the reasons for an unexpectedly high need for interim housing settings for participants, and to explore experiences with interim housing from the perspectives of participants and providers.

**Methods:** The study sample and data sources were the same as those described in the Housing Delays and Relocations study on the previous page.

### Key Findings:

- Participants experiencing delays prior to initial housing placement, and those requesting or requiring transfers after accessing their initial housing, needed a safe place to reside if they were unable or unwilling to double-up with others or stay in shelters or other institutions. These “interim housing” stays had several advantages, including enabling service providers to build trust with participants and allowing continuity in service engagement.
- Even when participants’ personal choices were driving the need for the interim stays, both participants and providers found them frustrating and stressful. The unique volatility of interim situations, and the singular focus on accessing promised permanent housing, affected the capacity to maintain trust and continuous service engagement. Specifically, it contributed to fluctuations in intensity and frequency of services, and flagged consumer interest in and case managers’ capacity to address non-housing recovery goals.
- While interim housing may not be necessary for all programs implementing the model, our study revealed numerous reasons and demands for safe, flexible interim housing options, and illustrated how they influence the effectiveness of consumer recovery, continuous service engagement, and housing stability.

## PRIMARY CARE

**Purpose:** To examine the effect of the At Home intervention on engagement in primary care and receipt of preventive health services among people experiencing homelessness and mental illness.

**Methods:** This study involved review of primary care charts from 100 randomly selected study participants. Data were obtained for the period from one year prior to study entry until one year after study entry. Data collected included participant diagnoses, preventative health services, and selected physiological measures.

**Key Findings:** The proportion of individuals who were engaged in primary care (defined as at least one visit to the same primary care provider in each of two consecutive six-month periods) was not different among participants in the HF and TAU groups. Rates of influenza immunization were very low among study participants. These findings demonstrate the need for new efforts that are specifically aimed at improving primary care delivery for individuals who are homeless and have mental illness, even when these individuals receive a Housing First intervention.



# CHAPTER 8

## LESSONS LEARNED AND IMPLICATIONS FOR POLICY AND PRACTICE

In the Toronto site of the At Home study, Housing First (HF) was successfully implemented in Canada's largest and most ethnically diverse city. The HF intervention resulted in a rapid reduction in homelessness across a diverse group of individuals experiencing homelessness and mental illness. At study end, HF participants had been stably housed for 80 per cent of the time compared to 54 per cent among Treatment as Usual (TAU) participants. In the last six months of the study, 72 per cent of HF participants were housed all of the time, 16 per cent some of the time, and 12 per cent none of the time; whereas 36 per cent of TAU participants were housed all of the time, 25 per cent some of the time, and 39 per cent none of the time.

The vast majority of people who are homeless and have mental illness would prefer to live in an independent unit rather than a group living facility. Rent supplements through the At Home project played a key role in the success of this scattered-site model.

HF was effective in improving other life domains. In particular, HF participants had statistically significant improvements in community functioning compared to TAU participants, in a setting where TAU participants received high levels of available community services. Thus these findings represent benefits to participants that are beyond what might be expected from receiving services from a variety of local organizations. Both HF and TAU participants experienced improvements in observer-rated community functioning and self-reported quality of life over the length of the study. Participants likely enrolled in the study at a time when they were in crisis, so some improvement for enrollees in both groups is an expected outcome. These findings illustrate the importance of using data from controlled trials such as the At Home study to accurately assess the degree of benefit from a particular intervention. In contrast, evaluations that assess outcomes in a single group of individuals, all of whom receive a specific intervention, are likely to overestimate the effectiveness of the intervention.

HF can result in cost savings, particularly for high need participants. HF cost \$21,089 per person per year on average for high need participants and \$14,731 per person per year for moderate need participants. Over the two-year study period, every \$10 invested in HF services resulted in an average savings of \$15.05 for high need participants and \$2.90 for moderate need participants. The cost savings among high need participants were driven by reductions in hospitalizations, health provider visits, and emergency department and shelter use. While shelter

use decreased among moderate need participants, there were increased costs for psychiatric hospitalizations.

These findings demonstrate that HF is a highly effective use of public dollars, even in a service-rich environment such as Toronto. This is particularly true for high need participants who have a history of frequent hospitalizations for mental illness and/or encounters with the justice system. For this population, economic analyses indicated that the Toronto site had the greatest cost savings of all five cities in the At Home study.

In addition, HF is an approach that successfully engages individuals with mental illness who have not been well-served by current approaches. Almost all of the individuals in the At Home study in Toronto had been homeless for years within the existing service system. Despite this fact, the majority were rapidly housed in adequate, affordable, and suitable settings within a few weeks to months of study entry.

One of the most important lessons learned from the At Home study is that most people with mental illness can live independently in the community with the right supports. The vast majority of people who are homeless and have mental illness would prefer to live in an independent unit rather than a group living facility. Rent supplements through the At Home project played a key role in the success of this scattered-site model. Another critical factor is the proper implementation of mental health supports for these individuals. Our program evaluation highlighted the importance of fidelity to a choice-based, recovery-

Another critical factor is the proper implementation of mental health supports for these individuals. Our program evaluation highlighted the importance of fidelity to a choice-based, recovery-oriented service delivery model.

oriented service delivery model. The evaluation process has also produced a wide range of suggestions for program adaptations that should be considered for future HF initiatives in Toronto and in other jurisdictions. These recommendations include:

- Implementation of the HF model needs to occur at both the program and system levels.
- HF programs should adapt multidisciplinary service models that comprehensively address complex needs and high-risk individuals. They should target individuals that other programs consider “difficult to serve” and should persist in engaging with these clients despite the challenges that will inevitably arise.
- Service teams can greatly benefit from training in evidence-based practices to better support recovery of people experiencing homelessness and mental illness. Adopting an integrated service approach that provides both clinical and housing supports will strengthen the service delivery model.
- Combining the HF philosophy with an anti-racism/anti-oppression framework is an important adaptation when working with populations that have experienced racialization and discrimination.
- Including the perspectives and recommendations of People with Lived Experience is an important component for the successful implementation of HF.
- A variety of housing options are necessary. Engagement with landlords and their staff is critical. It is vital to establish long-term relationships with landlords and to ensure that clinical and housing support teams maintain close and regular contact with landlords, especially in relation to clients who are encountering major challenges in adapting to being housed. The use of head leases may provide service and housing teams more flexibility in housing clients rapidly.

The At Home study in Toronto also identified challenges that will need to be overcome as the HF approach continues to be implemented.

- While the HF model is successful in housing the large majority of clients, further adaptation of the model is necessary to address the needs of the small group of individuals who do not achieve stable housing using this approach.
- More intensive services that focus on linking individuals with their communities are needed during the initial stages of adjustment, to counteract feelings of isolation, loss, and loneliness that may arise in some individuals after they have been housed.
- Many participants struggle with barriers to vocation, education, and community integration that may persist despite initial housing stability. Additional support is needed to overcome these barriers, which include discrimination related to race/ethnicity, sexual orientation, and mental health issues.

HF, while highly effective in ending homelessness, is not a cure for all of the challenges faced by participants. Recovery requires learning to manage symptoms in healthy ways, to develop new living skills, and, ultimately, to reclaim important social roles (such as neighbour, family member, friend, or coworker). Narrative data indicate that participants perceived housing as a catalyst for making positive life changes, one that enabled them to experience a sense of control, security, and safety in their lives and which was necessary to begin a process of recovery. For many participants, however, recovery is a lengthy process. Programs and policy makers should recognize that while rehousing individuals who are homeless represents an important short-term success, further substantial improvements in community functioning, quality of life, mental health, and substance use may take years to fully achieve.

Finally, HF should be one component of a multi-pronged and evidence-based approach to address the problem of homelessness in Canada. There is a need to continue to strive towards the goal of safe, affordable housing for all. The At Home study demonstrates conclusively that the problem of chronic homelessness is one that can be solved, and that in ending homelessness, we can achieve a better life for all Canadians.

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# APPENDIX A

Figure 10.1 At Home/Chez Soi Project Partners at the Toronto site

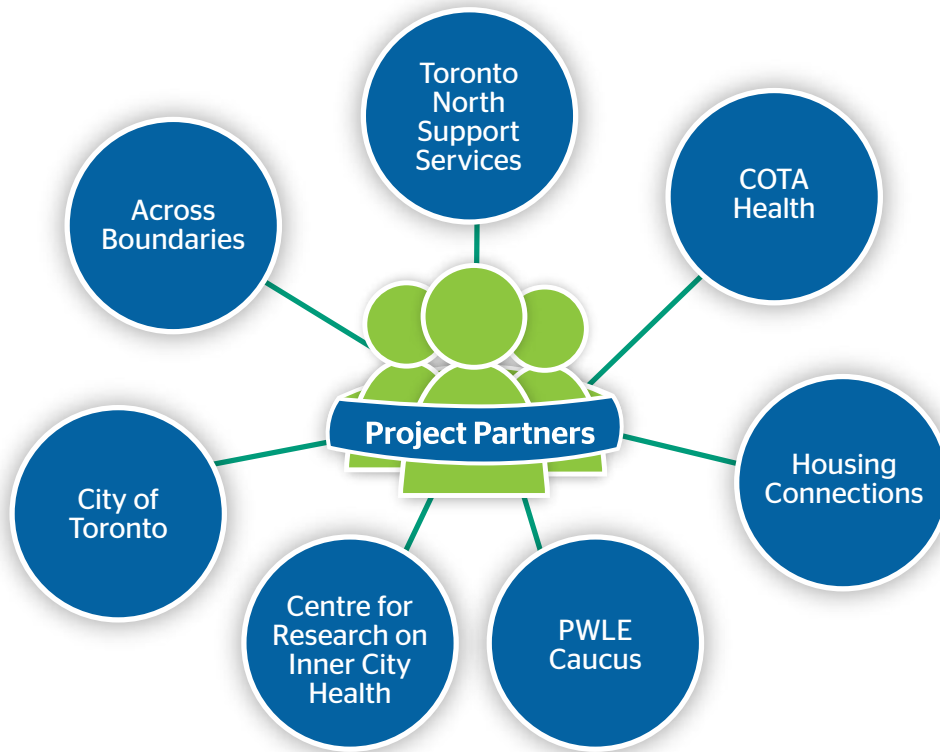


Figure 10.2 Site Governance

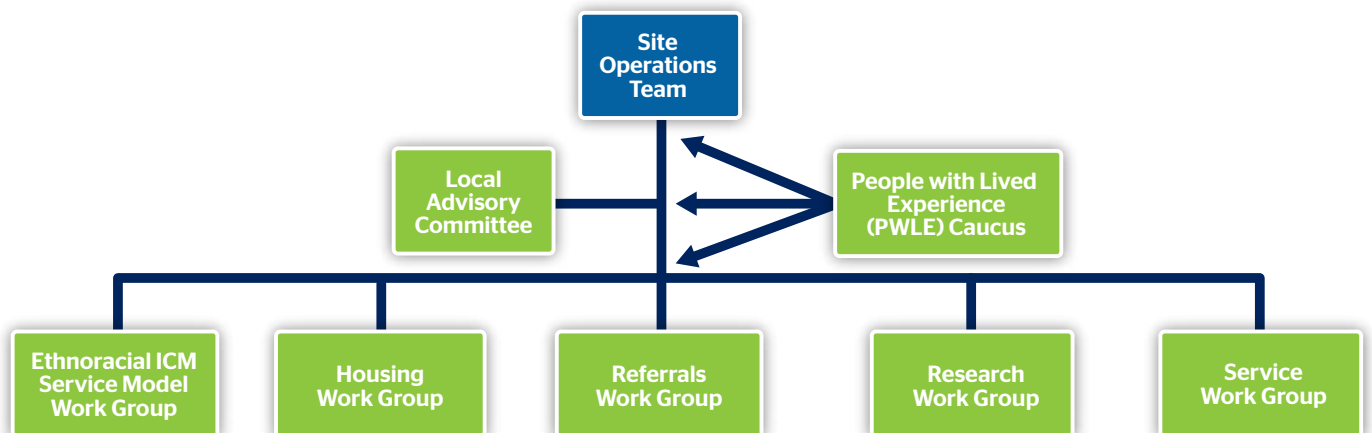
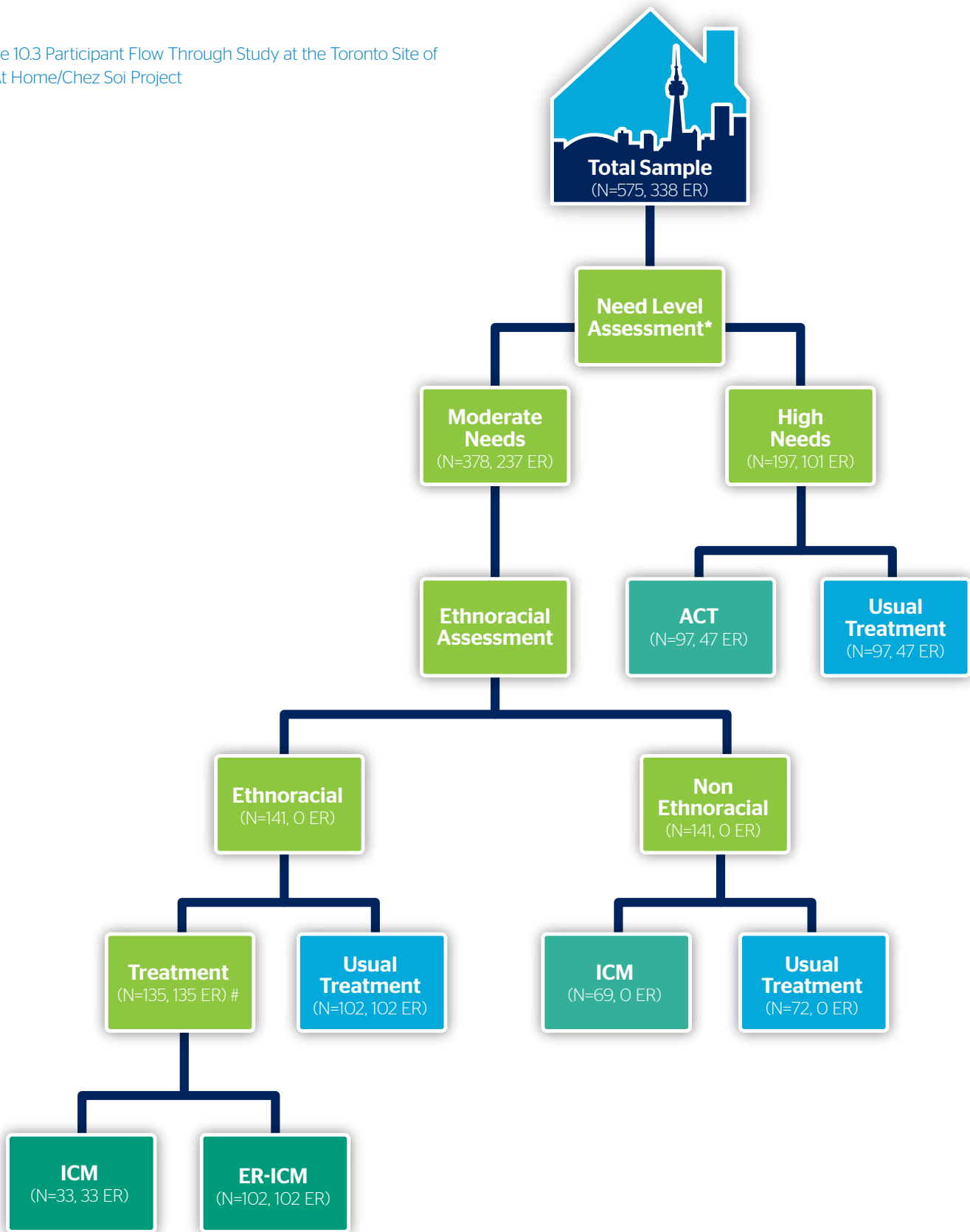


Figure 10.3 Participant Flow Through Study at the Toronto Site of the At Home/Chez Soi Project



# Participants with moderate needs who self-identified membership in an ethnoracial group were given a choice to participate in a regular Intensive Case Management (ICM) program or an ethnoracial-focused ICM program, as long as space was available in both groups.

# APPENDIX B

Table 10.1 Details Regarding Toronto Site Treatment Groups

NEEDS LEVEL	MODERATE NEEDS		HIGH NEEDS
TREATMENT ACRONYM	HF ICM	HF ER-ICM	HF ACT
TREATMENT NAME	Housing First with Intensive Case Management	Housing First with Ethnoracial Intensive Case Management	Housing First with Assertive Case Management
RENT ALLOWANCE	\$600	\$600	\$600
SERVICE TEAM	Intensive Case Management (ICM)	Intensive Case Management (ICM) with focus on ethnoracial diversity	Assertive Community Treatment (ACT)
NAME OF SERVICE TEAM	Toronto North Support Services	Across Boundaries	COTA Health
PARTICIPANT/STAFF RATIO	20:1	20:1	9:1
AVAILABILITY TO PARTICIPANT	5 days/week; 8 hours/day	7 days/week; 12 hours/day	7 days/week; 24 hours/day
LOCATION OF SERVICE	In the community	In the community	In the community
SERVICES PROVIDED	<ul style="list-style-type: none"> <li>Participants matched to a case manager who will work with the participant to develop a service plan</li> <li>Focus will be on independent living and providing supports that increase personal independence over time</li> <li>Case manager will accompany participant to appointments (with psychiatrist/social workers, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>Same as the regular ICM services with the addition of services oriented towards the ethnoracial population</li> <li>This service provider takes a more holistic approach to mental health care that recognizes spiritual, emotional, mental, physical, social, economic, cultural, linguistic, and broader environmental aspects of life, including social determinants of health</li> <li>Main goal of model is to assist participants to build a support network, including with family and friends.</li> </ul>	<ul style="list-style-type: none"> <li>Participants will have access to entire ACT team, which will include a psychiatrist and nurse</li> <li>ACT team will provide all relevant services, including case management, initial/ongoing assessment, psychiatric services, employment and housing assistance, family support and education, substance use services, and other services and support to allow the individual to live successfully in the community</li> </ul>
ADDITIONAL SERVICES		<ul style="list-style-type: none"> <li>Programs and initiatives that will also be available to participants:                             <ul style="list-style-type: none"> <li>Integrative peer support</li> <li>Skills building</li> <li>Social and recreational activities</li> <li>Support groups, alternative and complementary therapies (including art and music therapy)</li> <li>Creative expressions</li> <li>Community kitchen</li> <li>Individual and community outreach</li> </ul> </li> </ul>	
CRISIS SUPPORT SERVICES	Yes	Yes	Yes
NON-ENGLISH SERVICES	No	Yes	No
LENGTH OF TREATMENT	Minimum 1 year	Minimum 1 year	Minimum 1 year

Table 10.2 Definitions of inclusion criteria.\*

NEEDS LEVEL	HIGH NEEDS
ABSOLUTE HOMELESSNESS	Homelessness refers to those who lack a regular, fixed, physical shelter. This (conservative) definition is known as absolute homelessness, according to the United Nations, and includes those who are living rough in a public or private place not ordinarily used as regular sleeping accommodation for a human being (e.g., outside, on the streets, in parks or on the beach, in doorways, in parked vehicles, squats, or parking garages), as well as those whose primary night-time residence is supervised public or private emergency accommodation (e.g., shelter, hostel). Specifically, being homeless is defined as currently having no fixed place to stay for more than seven nights and little likelihood of obtaining accommodation in the upcoming month, or being discharged from an institution, prison, jail, or hospital, with no fixed address.
PRECARIOUSLY HOUSED	This refers to people whose primary residence is a Single Room Occupancy (SRO), rooming house, or hotel/motel. In addition, precariously housed individuals in the past year have had two or more episodes of being absolutely homeless, as defined above, in order to meet the criteria for inclusion.
RELATIVELY HOMELESS	This includes people whose regular housing fails to meet basic standards, such as: 1) living in overcrowded or hazardous conditions; 2) those at risk of homelessness, such as people who reside informally/non-permanently with friends or relatives (e.g., doubling-up, couch surfing); 3) those in transition (e.g., women, youth fleeing to transition houses/shelters from domestic abuse); 4) those who are temporarily without a dwelling (e.g., home lost for a relatively short period of time due to disasters such as a fire, or a change in economic or personal situation, such as marital separation or job loss; and, 5) those living in long-term institutions.
SERIOUS MENTAL DISORDERS	Serious mental disorders are defined by diagnosis, duration, and disability, using observations from referring sources, indicators of functional impairment, history of recent psychiatric treatment, and current presence of eligible diagnosis as identified by the Mini International Neuropsychiatric Interview (major depressive, manic, or hypomanic episode, post-traumatic stress disorder, mood disorder with psychotic features, psychotic disorder).

\*From: <http://bmjopen.bmj.com/content/1/2/e000323.full>



# APPENDIX C

## ADDITIONAL SITE-SPECIFIC SUB-STUDIES

### Anti-Racism and Anti-Oppression (AR/AO) Framework

**Purpose:** To understand how anti-racism and anti-oppression frameworks of practice are conceptualized, and identify elements within these frameworks that apply to service provision toward racialized groups.

**Methods:** Comprehensive review of the literature, providing a conceptual and theoretical foundation of these frameworks.

**Key Findings:** Although anti-racism and anti-oppression as philosophies of practice have some limitations, they can bring positive changes to mental health service delivery. Both have the advantage of explicitly addressing crucial issues that permeate service provision and society at large. The main ingredients in these frameworks include: empowerment, education, alliance building, language, alternative healing strategies, advocacy, and social justice/activism.

### AR/AO Practice Evaluation and Fidelity Tool

**Purpose:** A key objective of the implementation evaluation process was to better understand the third intervention arm of Toronto's At Home/Chez Soi project, which combines the Housing First philosophy with an anti-racism/anti-oppression framework (AR/AO framework - see above) to engage and provide support services to clients from racialized groups experiencing homelessness and serious mental health problems.

**Methods:** A literature review, interviews with key informants, and surveys of frontline providers and managers of programs serving racialized communities were conducted to capture specific elements which are key to AR/AO practice.

#### Key Findings:

- Key elements of the AR/AO philosophy related to agency supports include: a formalized commitment to AR/AO practices by the agency; supervisory and administrative staff with relevant experience in AR/AO practice; identifying and labeling racism and oppression at the workplace; a welcoming physical environment; a commitment to hiring and ongoing training of staff from the communities served by the agency; and, advocacy for system-level changes.
- Key staff practices of the AR/AO model include: asking explicitly about experiences of racism and oppression, facilitating action plans to address experiences of discrimination, and taking a holistic approach to health and wellness.
- In general, the AR/AO approach fosters recovery through a number of pathways, including empathic validation, empowerment, role modeling, and a corrective experience of inclusion, helping to heal and inspire towards recovery goals

and community integration. These findings have informed the development of an assessment tool to measure fidelity to AR/AO principles within the context of service delivery to racialized persons with mental illness. Validation of this fidelity tool is underway; content expert interviews and confirmatory methods are being used to achieve consensus on the key domains and indicators for the tool.

### Landlords

**Purpose:** This sub-study examined the role of landlords with regard to program participants getting, keeping, and losing housing prior to study entry.

**Methods:** The perspectives of landlords (n=16), housing and clinical service teams (n=18), and program participants (n=60) were solicited through both key informant interviews and focus groups.

**Key Findings:** This study found that landlords had substantive impact on HF implementation, including impact on participants getting, keeping, and losing housing prior to study entry. For example, landlords had strong influences on processes of acquiring housing, including screening, applying, and soliciting references. The quality of the relationship between landlords and tenants and landlord tolerance were also important in participants' capacity to maintain housing. Finally, landlord discriminatory behaviours, such as coercion and harassment, emerged as important factors in affecting housing placement and maintenance. One recommendation arising from this analysis is that education about mental health and disability is an important step towards combating stigma and giving landlords tools to understand mental health behaviour and to be helpful to program participants.

## Discrimination Studies

### Discrimination in Health Care Settings

**Purpose:** 1) To examine the prevalence of perceived discrimination due to homelessness/poverty, mental illness/alcohol/drug-related problems, and race/ethnicity/skin color while seeking health care in the past year among racially diverse adults experiencing homelessness and mental illness; and, 2) To identify to what extent self-report measures of psychiatric symptomatology and substance use, and frequency of health service utilization, are associated with various forms of perceived discrimination in health care settings.

**Methods:** We used baseline data from the Toronto site of the At Home/Chez Soi randomized controlled trial of Housing First for persons experiencing homelessness and mental illness (n=550). Bivariate statistics and multivariate logistic regression models were used for the analysis.

### Key Findings:

- Perceived discrimination related to homelessness/poverty (30.4 per cent) and mental illness/alcohol/substance use (32.5 per cent) is prevalent among ethnically diverse adults experiencing homelessness and mental illness in health care settings. After controlling for relevant confounders and presence of psychosis, all types of discrimination in health care settings were associated with frequent emergency department use, severity of lifetime substance use and mental health problems.
- Understanding the experience of discrimination in health care settings and associated health care utilization is the first step towards designing policies and interventions to address health disparities among vulnerable populations. This study added to the knowledge base in this important area.

### Discrimination Experiences

**Purpose:** To understand discrimination experiences of participants who self-identified as ethnoracial minorities and whether/how homelessness, mental illness, race, and gender influenced those experiences.

**Methods:** This mixed methods study assessed quantitative measures of discrimination experiences for the 231 ethnoracial moderate needs participants. Qualitative assessments of discrimination experiences were captured from in-person interviews with 36 of these individuals.

### Key Findings:

- Quantitative analysis on the 231 ethnoracial moderate needs participants revealed very high prevalence rates of perceived discrimination related to homelessness/poverty (61.5 per cent), race/ethnicity/skin colour (50.6 per cent), and mental illness/substance use (43.7 per cent). Immigrants (compared to Canadian-born participants) and those who had been homeless three or more years reported higher perceived discrimination on all three domains.
- Based on these findings, qualitative analysis on the 36 interviews focused more closely on the two-thirds who were immigrants. Three key themes emerged: 1) self-isolation from friends and family due to stigma; 2) old and new labels/identities – experiences of discrimination due to homelessness and mental illness were more predominant due to newness of the labels; and, 3) the role of cultural identity and the “homeland” – perceptions of mental illness and homelessness in their homeland culture affected how they interpreted and adjusted to these new labels, and thus to the stigma and discrimination associated with them.

### Coping and Resilience

**Purpose:** To identify key stressors and coping and resilience strategies among participants who self-identified as ethnoracial minorities, and explore the interplay between social context and coping experiences.

**Methods:** In-person interviews with 36 study participants self-identifying as ethnoracial, and meeting criteria for moderate needs on mental health measures.

### Key Findings:

- Dominant stressors characterizing their social environments included powerlessness and worthlessness, racial discrimination, and cultural disconnectedness; these interacted with each other in complex ways. For example, homelessness and mental health problems engender a sense of powerlessness, worthlessness, and social isolation, which is both compounded and shaped by the racial discrimination and cultural disconnection associated with ethnoracial and/or immigrant status. And stressors associated with homelessness and mental illness both affected and were affected by the acculturation process and cultural disconnect, which in turn complicated coping opportunities and strategies.
- We examined contextual effects on their three most common coping strategies: socializing, finding an “anchor,” and engaging in meaningful activities. We found that coping strategies were largely inchoate and took the form more of activities they yearned to undertake than as productive strategies. For example, socializing and seeking support or help from others was hindered by an entrenched lack of trust, “anchors” to rely on were frequently undefined or physically and emotionally inaccessible, and partaking in meaningful activities was thwarted by lack of tools and resources. By overtly drawing the link between specific contextual challenges and articulating their effects on coping, we exposed potential for bolstering coping capabilities and resiliencies.

## Physical Health and Primary Care Studies

### Cardiovascular Disease (CVD)

**Purpose:** To examine CVD risk factors and 30-year CVD risk in a population of individuals experiencing homelessness and mental illness.

**Methods:** CVD risks factors were assessed in 352 individuals experiencing homelessness and mental illness in Toronto, Canada, at the time of their study entry. The 30-year risk for CVD (coronary death, myocardial infarction, and fatal or nonfatal stroke) was calculated using published formulas and examined for association with need for mental health services, sex, diagnosis of psychotic disorder, ethnicity, access to a family physician and diagnosis of substance dependence.

**Key Findings:** The 30-year CVD risk for study participants was  $24.5 \pm 18.4$  per cent, more than double the reference normal of  $10.1 \pm 7.21$  per cent. In univariate analyses, male sex and diagnosis of substance dependence were associated with increased CVD risk (OR 3.99, 95 per cent CI: 2.47-6.56,  $p < 0.001$  and OR 1.94, CI: 1.23-3.06,  $p = 0.004$ , respectively), while ethnicity was associated with reduced CVD risk (OR 0.62, CI: 0.39-0.97,  $p = 0.040$ ). In adjusted analyses, only male sex (OR 5.14, CI: 3.00-8.81;  $P < 0.001$ ) and substance dependence (OR 1.78, CI: 1.05-3.00,  $p = 0.032$ ) were associated with increased CVD risk. Higher rates of smoking and cocaine use were reported among non-ethnoracial (vs. ethnoracial) individuals ( $P \leq 0.014$ ). Compared to women, men were more likely to have hypertension, lower BMI, and larger waist-to-hip ratios ( $P \leq 0.008$ ).

# APPENDIX D

## CRITERIA FOR ESTABLISHING NEED LEVEL

**HIGH NEEDS** participants need to meet the following criteria:

1. have a MCAS score of 62 or less

and

2. have a MINI diagnosis of psychotic or bipolar disorder or an observation of psychotic disorder on the eligibility screening instrument (i.e., answered “yes” to at least two of Questions 6-10 in the Eligibility Screening Questionnaire)

and

3. had to meet one of following three criteria:
  - i) had indicated “yes” (or “don’t know” or declined) to having been hospitalized for mental illness two or more times in any one year in the last five years;

or

- ii) have indicated co-morbid substance use;

or

- iii) have answered “yes” (or “don’t know” or declined) to recent arrest or incarcerations.

**All other participants who met study eligibility criteria but did not meet the criteria for the high needs group were considered moderate needs<sup>23</sup>**

