



MONTREAL FINAL REPORT

At Home/Chez Soi Project



Mental Health
Commission
of Canada

Commission de
la santé mentale
du Canada

AT HOME/CHEZ SOI PROJECT: MONTRÉAL SITE FINAL REPORT

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MAIN MESSAGES

FROM THE MONTRÉAL AT HOME/CHEZ SOI PROJECT

In Montréal, 469 people who were homeless and living with mental illness were recruited between October 2009 and May 2011 to participate in the At Home/Chez Soi study. Among these, 163 were classified as having high needs, and the remaining 306 as having moderate needs. Participants with high needs were randomly assigned either to receive a Housing First (HF) intervention, with an Assertive Community Treatment team, or usual services. Participants with moderate needs received a HF intervention delivered by one of two Intensive Case Management teams, or usual services. The Montréal site achieved exceptional follow-up rates of 91 per cent overall, which increases the reliability of its findings. The project yielded three key conclusions.

1

The Housing First approach is feasible in Montréal.

The housing team found 73 landlords located in many different neighbourhoods of Montréal who were willing to offer one or more of their apartments to Chez Soi participants. Almost all of the 285 participants who were recruited to a HF group were housed within about three months of recruitment, in apartments of their choice. The teams continued to provide services to the great majority of participants until the end of the study. As a result of sustained implementation efforts, when the project ended at the end of March 2013, the teams were following the HF model more and more closely.

2

The Housing First approach is effective.

- *HF participants obtained and retained housing to a much greater extent than those in the treatment as usual (TAU) groups.* Among high need participants, in the last six months of the study, 60 per cent of those in the HF group were housed all of the time, compared to 31 per cent for the TAU group; 21 per cent were housed none of the time, compared to 59 per cent for the TAU group. Also in the last six months of the study, the differences were larger among moderate need participants: 72 per cent of those in the HF group were housed all of the time, compared to 29 per cent for the TAU group; seven per cent of those in the HF group were housed none of the time, compared to 52 per cent for the TAU group.
- *HF participants also experienced many gains in other domains.* Moderate need participants assigned to the HF group reported a greater improvement on a standardized measure of quality of life over the study period than their TAU counterparts. Over the same period, the high need HF group, and the moderate need HF groups, also showed more improvements in measures of community functioning. In-depth interviews conducted at study entry and 18 months later, on a representative 10 per cent sample of both high need and moderate need participants, reveal many more benefits. Among others, HF participants were much more likely to report improvements in their mental health, decreases in stress and anxiety, greater re-establishment of connections with their family members, and reductions in disordered substance use. For people with moderate needs especially, overall life trajectories were much more likely to be positive, compared to those of people receiving services as usual.

3

Housing First reduces the costs of other services.

On average, the intervention cost \$22,482 per person per year for high need participants and \$14,029 for moderate need participants. This cost is almost completely offset by savings in costs of other services, notably hospitalizations, shelters, and other types of housing. Over the two-year period following participants' entry into the study, every \$10 invested in HF services resulted in an average savings of \$8.27 for high need participants and \$7.19 for moderate need participants.

In short, the study has shown that it is feasible in Montréal to house many people who are homeless and living with mental illness in subsidized apartments of their choice and greatly increase their housing stability and the quality of their lives, at minimal additional cost to society.

EXECUTIVE SUMMARY

FROM THE MONTRÉAL AT HOME/CHEZ SOI PROJECT

Homelessness is a serious and growing concern in Québec. Although no reliable, comprehensive data on the numbers and characteristics of people who are homeless in Montréal are available, data collected by the *Service d'hébergement d'urgence* (Emergency Shelter Service) show a steady increase in numbers of beds and occupancy rates in shelters during the last decade.

Montréal was one of five Canadian cities in which the feasibility, effectiveness, and cost-effectiveness of the Housing First (HF) approach was evaluated under the leadership of the Mental Health Commission of Canada (MHCC). Between October 2009 and May 2011, a team of interviewers recruited 469 people who were homeless and living with mental illness to participate in the At Home/ Chez Soi study. Among the participants, 163 were classified as having high needs, due to the more disabling nature of their mental illness and/or more challenging behaviour issues, and the remaining 306 as having moderate needs. Participants with high needs were randomly assigned either to receive a HF intervention (N=81), with a high-intensity Assertive Community Treatment (ACT) team, or treatment as usual (TAU) services (N=82). Participants with moderate needs received a HF intervention delivered by one of two Intensive Case Management (ICM) teams (N=204), or TAU services (N=102). A separate housing team recruited landlords and focused on the housing component of the intervention, working in tandem with the clinical teams.

The teams were managed by different institutions working in partnership:

the ACT team and one of the ICM teams were managed by the *Centre de Santé et Services sociaux* (Health and Social Services Centre) *Jeanne-Mance*, with the psychiatry department of the *Centre hospitalier de l'Université de Montréal* (University of Montréal hospital) contributing a psychiatrist to the ACT team. Diogène, a community organization, oversaw the other ICM team. The Douglas Mental Health University Institute managed the housing team and the rent supplements. A men's shelter, Welcome Hall Mission, helped manage rent payments by participants. People with lived experience participated in the project as advisors on all important committees and as members of clinical teams.

Following recruitment, participants were invited to respond to several standardized questionnaires every three months, for up to 24 months. These questionnaires were designed to assess, in particular, participants' quality of life, functioning, mental and physical health, substance use problems, where they had been staying, their income and employment, and what health, social, and justice services they had used. Follow-up rates in Montréal remained very high for both groups until the end (more than 91 per cent of all

those originally recruited). Interviewers also met with a representative sample of 10 per cent of participants (N=46) shortly after study entry for in-depth interviews to learn about their lives up until the time they entered the study. Interviewers met these participants again 18 months later and asked them about their lives during the time since the study started. Additional qualitative sub-studies were also conducted on the housing experience for HF participants, landlords, and janitors; on the experiences of family members of HF and TAU participants; and on the impact of people with lived experience as peers in the clinical teams. An experimental sub-study, conducted with volunteers among the housed moderate need participants, tested the Individual Placement and Support (IPS) model of supported employment.

The 469 participants were mostly (68 per cent) male. On average, participants were 44 years old when they entered the study, with 62 per cent between 35 and 54 years of age. They had been homeless, on average, for 52 months over their lifetime when they entered the study. The first set of in-depth interviews revealed life stories which, while highly specific, nonetheless tended to share some common elements.

Many participants, especially women, had grown up in emotionally difficult circumstances. Mental illness, often compounded by substance use disorders, had further diminished these individuals' ability to develop and maintain supportive relationships. They described an early existential discomfort (*mal de vivre*) rooted in unsatisfactory relationships that had continued into adulthood.

The HF intervention proved feasible in Montréal. The housing team found 73 landlords located in many different neighbourhoods of Montréal who were willing to offer one or more of their apartments to Chez Soi participants. Almost all of the 285 participants who were recruited to HF groups were housed within about three months of recruitment, in apartments of their choice. The teams continued to provide services to the great majority of participants until the end of the study. As a result of sustained implementation efforts, when the project ended at the end of March 2013, the teams were following the HF model more and more closely.

Housing First also proved effective. Participants with high needs who were assigned to HF spent about 60 per cent of their nights in permanent housing from the time of study entry until the end of follow-up, compared to 18 per cent for the TAU group. The corresponding percentages for moderate need participants were 79 per cent and 31 per cent. Looking at the data differently, among high need participants, in the last six months of the study, 60 per cent of those in the HF group were housed all of the time, compared to 31 per cent for the TAU group; and 21 per cent were housed none of the time, compared to 59 per cent for the TAU group. Also in the last six months of the study, the differences were larger among moderate need participants: 72 per cent were housed all of the time, compared to 29 per cent for the TAU group; and seven per cent were housed none of the time, compared to 52 per cent for the TAU group.

In addition, moderate need participants assigned to the HF group reported a greater improvement on a standardized measure of quality of life over the study

period than their TAU counterparts. Over the same period, the high need HF group, and the moderate need HF groups, also showed more improvements in a measure of community functioning. No statistically significant differences were noted on other quantitative outcome measures, however.

In-depth interviews conducted with both high need and moderate need participants revealed more notable differences between the experiences of HF compared to TAU participants, especially for moderate need participants. The former were three times more likely to note an improvement of their mental health after 18 months, and reported a decrease in stress and anxiety, and greater feelings of peace, more often than TAU participants. Participants receiving HF were twice as likely to say that their use of substances had decreased. A higher proportion of HF participants was re-establishing family ties. They were also half as likely to report suicidal ideation as TAU participants, and more prone to report that they had faith in the future, that they were starting to make plans, and that they viewed life in the streets as a thing of the past. Nearly two-thirds of interviewed HF participants mentioned having developed feelings of security and privacy, which they did not have in the streets; others did not, attributing this to sub-standard apartment quality. Participants also often explained why HF had resulted in these positive changes. For example, the stability and security of being in their own apartment reduced the need to self-medicate using alcohol or drugs. Participants in the HF groups stressed the importance of the clinical teams, who, by their continued, non-judgmental, and regular support, and by empowering participants to make their own decisions, helped them overcome the challenges of living in an apartment and make progress toward the attainment of their own goals.

Through interviews with landlords and superintendents, we concluded that although some HF participants did encounter stigma, especially when a concurrent substance use disorder was present, most of them were treated as regular tenants. Many landlords showed empathy and tolerance towards HF

participants. Finally, family members of HF participants also noted positive outcomes of the intervention: relief that their relative was being helped by professionals, as well as that they seemed to be finding the motivation to improve their situation.

On average, the intervention cost \$22,482 per person per year for high need participants and \$14,029 for moderate need participants. This cost is almost completely offset by savings in costs of other services, notably hospitalizations, shelters, and other types of housing. Over the two-year period following participants' entry into the study, every \$10 invested in HF services resulted in an average savings of \$8.27 for high need participants and \$7.19 for moderate need participants.

Thirty-four per cent of participants receiving IPS supported employment obtained competitive employment, compared to 22 per cent of a comparison group, which received HF services but only normally available vocational services. The difference, however, was not large enough to be statistically significant (that is, for us to rule out that it was due to chance alone). Finding, training, and keeping suitable employment specialists proved very challenging, and for only about a nine-month period was the supported employment program fully staffed and operating at a good level of fidelity to the IPS model. Both participants and employment specialists noted that continued substance use and criminal records posed significant obstacles to finding work.

An experimental comparison of outcomes obtained by the institutional ICM team (CSSS Jeanne-Mance) and the ICM team managed by the community organization Diogène, found no statistically significant difference in outcomes between the teams. Qualitative interviews of participants suggested that differences among individual case managers are more salient from their point of view than overall differences in the teams.

Finally, the integration of persons with lived experience into the clinical teams helped both clinicians and people with lived experience to learn from each other, so that interventions were better adapted to the needs of the participants.

The main implications of the study for homelessness policy and practice in Montréal are:

1. Access to HF services similar to those developed by Pathways to Housing in New York City and in the Chez Soi project should be increased. If such programs were sufficiently scaled up, the number of people who are chronically homeless and living with a mental illness in Montréal would fall significantly. This has two specific implications:
 - a) The number of available rent supplements needs to be increased, as most participants prefer being housed in independent private-market apartments, and can live in such settings successfully. Increased access to affordable housing needs to be defined in a way that makes room for rent supplements.
 - b) Training and consulting services need to be developed to promote high-fidelity implementation of HF programs.HF programs should be viewed as an important component (though by no means the only one) of a systemic approach to ending homelessness in Montréal.
2. Additional research needs to be carried out to better understand how the effectiveness of HF services can be increased for the minority of people for whom it proved ineffective.
3. Existing services for people with mental illness who are homeless should seek to emulate as many as possible of the aspects of HF for which participants expressed appreciation: rapid access to stable housing, intensive long-term support by ACT and ICM teams, a non-judgmental attitude on the part of case managers, and encouraging clients to make their own decisions.

CHAPTER 1

INTRODUCTION

Homelessness: A Growing Concern in Montréal

Homelessness is a growing concern in the province of Québec and, more specifically, in Montréal. As the headline of a leading Montréal newspaper proclaimed in April 2012, “Homelessness is exploding in Montréal,” referring to the increase in the number and diversity of people who were homeless (Le Devoir, April 20, 2012). Community organizations all report a sharp increase in the number of people experiencing homelessness (RAPSIM, 2013). In the winter of 2012-2013, between December 15 and March 31, average daily occupancy rates of Montréal’s men’s emergency shelters rose from 90 per cent of 567 places (53,853 bed nights in total) in 2008-2009 to 95 per cent of 658 available places (66,633 bed nights) – a 24 per cent increase. During the same period, women’s emergency shelters recorded 5,579 bed nights, compared to 4,242 in the winter of 2008-2009, a 32 per cent increase in five years. Many emergency shelters for women report regularly having to turn applicants away because of overcrowding. Thus, although no comprehensive data are collected on the number of people who are homeless in Montréal, it is clear from these multiple sources of information that the problem is worsening.

The rise in homelessness also represents a growing public health concern: people experiencing homelessness have a much higher prevalence of physical and mental illnesses, including substance use, than the general population; they are more likely to be victims of physical abuse and aggression; and their mortality rate is two to 31 times higher than that of the general population, depending on studies and subgroups (Frankish, Hwang, & Quantz, 2005).

Community organizations all report a sharp increase in the number of people experiencing homelessness.

A Wide Array of Services

Homelessness is increasing in Montréal despite the availability of a wide array of organizations, both public institutions and not-for-profit organizations, to help people in need.

The main public institution with a particular focus on people who experience homelessness is the *Centre de Santé et Services sociaux (CSSS) Jeanne-Mance* (Jeanne-Mance Health and Social Service Centre). Every year, it serves more than 4,000 men and women who are homeless through different programs: *Équipe itinérance*, *Clinique des jeunes de la rue*, and *Urgence Psychosociale - Justice* (Homelessness Team, Street youth clinic, and Psychosocial-Justice Emergency). *Le Centre de réadaptation en dépendance de Montréal* (Montréal substance abuse rehabilitation centre) has a special program for people

experiencing homelessness with substance use issues, called *Itinérance/ sans domicile fixe* (Homelessness/ No fixed address). In order to improve interactions between the police and people who are homeless, a collaborative initiative between the Montréal Police Service and the CSSS Jeanne-Mance was initiated in 2009: *L'équipe mobile de référence et d'intervention en itinérance (EMRII)* (Mobile referral and intervention team for homeless people), in which police officers and social workers collaborate to help people experiencing homelessness who have involvement with the criminal justice system.

A Montréal sub-study of the *Chez Soi* project designed to map the network of available resources counted 93 organizations exclusively serving people experiencing homelessness or at risk of experiencing it: 18 organizations provide emergency shelter, 57 provide

other services for people experiencing homelessness specifically, and 18 help people experiencing homelessness as well as other persons in need. Another 19 organizations serve low-income populations, including people who are homeless (Fleury, Grenier, Lesage, Ma, & Ngui, February 2014). This study also noted that most of the organizations serving people who are homeless in Montréal have established significant informal links with one another (Fleury et al., In press, February 2014).¹

In terms of affordable housing, the City of Montréal has been involved since 2002 in the development and operation of not-for-profit, community-based housing units intended specifically for people experiencing homelessness or at risk of experiencing it. It has done so in collaboration with a provincial government organization: the *Société d'habitation du Québec* (SHQ) (Québec Housing Agency).

¹ This study also noted that collaboration between less specialized community organizations and public institutions could be improved, in order to increase the effectiveness of services provided to people experiencing homelessness who also have concurrent conditions such as substance use and severe mental illness. These individuals could then be more easily transferred to the care of specialized institutions, which would allow less specialized community organizations to concentrate their resources on those with lower levels of need.

Funding for these various services comes from multiple levels of government. Many key health and social services, especially in the institutional sector, are funded by the provincial government. The City of Montréal subsidizes front-line providers such as emergency shelters, day centres, street workers, etc. The federal government also has been funding community organizations through the Homelessness Partnering Strategy (HPS).

An Evolving Policy Context

In 2008, when the Chez Soi project was introduced, homelessness was the subject of public debate in Québec. The provincial government had established a parliamentary commission on homelessness. More than 145 briefs were submitted, and 104 individuals and groups were heard. The document *L'itinérance au Québec - Cadre de référence* (Homelessness in Québec - A framework for policy), published a few months later, set four main goals to address the issue of homelessness at the provincial, regional, and local levels: (1) strengthen prevention; (2) improve access to and effectiveness of emergency response services; (3) similarly, improve access to and effectiveness of treatment and rehabilitation services; and, (4) improve knowledge, research, and training (MSSS, 2008).

This framework formed the basis of the 2010-13 interministerial action plan on homelessness (*Plan d'action interministériel en itinérance 2010-2013*) that was made public in December 2009 and proposed to focus on best practices to address homelessness. The action plan identified the Housing First (HF) model as an interesting approach to explore for people with mental illness facing chronic homelessness (*Plan d'action interministériel en itinérance 2010-2013*, 2009). Relatedly, as such teams are an integral part of the HF model, the Québec 2006 - 2010 Mental Health Action plan (*Plan d'action en santé mentale 2006 - 2010*) also set targets for the numbers of

people with mental illness (not specifically homeless) to be served by Assertive Community Treatment (ACT) and Intensive Case Management (ICM) teams² in the province. These targets were (and indeed, remain) far from met in Montréal and in most of the province at the time the Chez Soi project started.

The At Home/Chez Soi Project

The At Home/Chez Soi project was launched in this context in 2008 by the Government of Canada, through funding from Health Canada to the Mental Health Commission of Canada (MHCC). As described in greater detail below, the project's central aim was to implement and evaluate, using a randomized controlled design, the HF model in Canadian settings.

The project received a mixed reception in Montréal at the outset. Several community organizations felt project funds should have been directed to them rather than to entirely new programs. Some criticized the randomization as unethical, because of the disappointment it could generate, since participants would be randomly assigned either to a group who would receive clinical services and subsidized housing or to a treatment as usual group, who would continue to receive services as otherwise available. They also feared that at the end of the project, after March 31, 2013, participants would return to the streets after discontinuation of MHCC funding. Moreover, the fact that rent subsidies were given to private landlords was a philosophical stumbling block for many community organization stakeholders, who believe public funds for affordable housing should be injected directly into social housing (RAPSIM, 2010).

² Assertive Community Treatment (ACT) and Intensive Case Management (ICM) teams are composed of professionals from various disciplines related to health and social services, with a relatively small staff to client ratio (respectively, 1:10 and 1:17 in the At Home/Chez Soi study). ACT teams offer integrated treatment, support, and rehabilitation services directly, while ICM teams broker more services. Staff of both types of teams see clients in their "natural" environments (e.g., streets, shelters, homes, etc.) rather than in institutional settings. As a result, such teams need to be highly mobile. They are designed to be highly adaptable to the needs and particularities of each client.

CHAPTER 2

DESCRIPTION OF PROGRAMS

Rationale for Testing the Pathways to Housing Variant of Housing First

The At Home/Chez Soi study, a \$110 million pragmatic randomized controlled trial, began recruiting participants in October 2009 in five Canadian cities at once: Vancouver, Winnipeg, Toronto, Montréal, and Moncton. The project aimed to evaluate the effectiveness and cost-effectiveness of Housing First (HF) – a particular approach to helping people who are homeless and experiencing mental illness, developed in New York City by the organization Pathways to Housing. Effectiveness was conceived of first and foremost in terms of housing stability, but also in terms of quality of life, mental and physical health status, community functioning, community integration, etc.

The HF model, as implemented in the Chez Soi project, involved offering people who were homeless and living with a mental illness immediate access to a subsidized apartment of their choice, most often in private-market scattered site rental units, combined with clinical services tailored to their needs. No prior conditions (such as sobriety or participation in treatment) were imposed, other than agreeing to the visit of a staff person from the program at least once per week.

This approach differs from the traditional continuum of care model, in which people experiencing homelessness need to progress through a series of

increasingly autonomous housing situations, on the condition of satisfactory behaviour. Thus, HF provides immediate access to housing for many individuals experiencing homelessness who are not perceived as “housing ready” by traditional programs. Studies carried out in the United States have found that HF programs significantly increase housing stability, while the costs of the intervention are largely, if not completely, offset by a reduction in spending on acute health care services, shelters, and justice and correctional services.

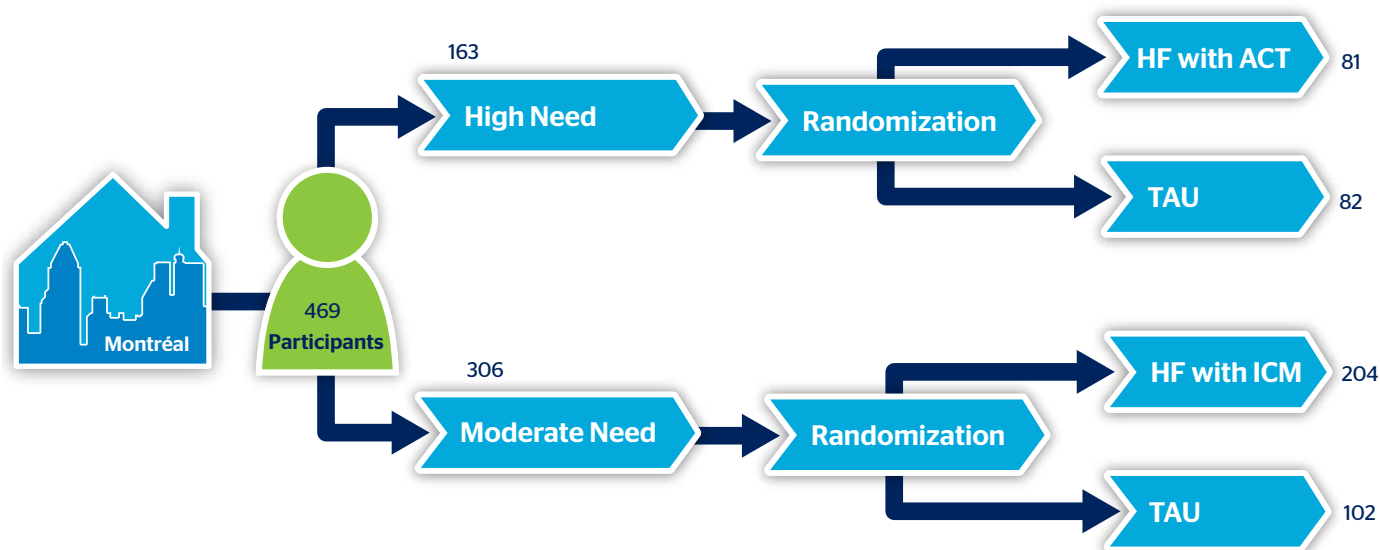
The specific variant of HF tested in At Home/Chez Soi also differs from some other programs that provide immediate access to housing, in that it emphasized giving people as much choice as possible over their place of residence. The great majority of participants chose scattered site, private-market apartments, distributed across several neighbourhoods according to their preferences. A mobile team provided long-term support to each participant and remained engaged with them even if they lost their housing or wanted to find alternative housing. As developed in New York City at Pathways to Housing, HF is designed to serve people who are homeless and living with serious mental illness, and includes delivery of integrated treatment, rehabilitation,

and support services by means of an Assertive Community Treatment (ACT) team. In Chez Soi, a variant of this was also tested, which was designed to serve people with more moderate needs, with support services provided by an Intensive Case Management (ICM) team. In offering immediate access to scattered site apartments to people with moderate needs, this adaptation of HF resembled Toronto’s Streets to Homes program. Staff in both ACT and ICM teams were trained in motivational interviewing, harm reduction, recovery-oriented approaches, etc. Their guiding aim was to help participants build on their strengths to achieve their own goals and dreams.

In contrast, some “low-barrier housing” programs also offer immediate access to housing, but only in one of a limited number of congregate housing sites, which are staffed and organized to be able to accommodate clients with serious mental illness and/or substance use. The Pathways version of HF was selected because of its emphasis on client choice; as participants usually choose to live in private-market apartments, it leads to more people integrating into mainstream residential settings. It is thus more consistent with the recovery orientation that is now being advocated for and progressively integrated into mental health service delivery.

The specific variant of HF tested in At Home/Chez Soi also differs from some other programs that provide immediate access to housing, in that it emphasized giving people as much choice as possible over their place of residence. The great majority of participants chose scattered site, private-market apartments, distributed across several neighbourhoods according to their preferences.

In Montréal, 469 participants were recruited between October 2009 and May 2011, and assigned to different groups depending on their level of need, either high need (HN) or moderate need (MN). HN participants were randomly assigned either to HF with an ACT team (N=81) or treatment as usual (TAU, N=82). Participants with moderate needs were randomly assigned to one of the two Intensive Case Management (ICM) teams (N=204) or to TAU (N=102).



Study Design

In Montréal, 469 participants were recruited between October 2009 and May 2011, and assigned to different groups depending on their level of need, either high need (HN) or moderate need (MN).³ HN participants were randomly assigned either to HF with an ACT team (N=163) or treatment as usual (TAU, N=82). Participants with moderate needs were randomly assigned to one of the two Intensive Case Management (ICM) teams (N=204) or to TAU (N=102). A single housing team, distinct and independent of the clinical teams, recruited landlords, dealt with leases, and had primary responsibility

for issues related to housing, all the while collaborating closely with each of the clinical teams. Participants assigned to HF were quickly offered help in accessing an apartment of their choice (in terms of neighbourhood, type of building, etc.), with a rent subsidy set so that they only had to pay 25 per cent or 30 per cent of their income (the latter if the rent included heat) for the rent. In Montréal, the rent subsidy averaged \$375 per month, and the average rent (for a one-bedroom apartment) was \$575. All the teams were trained and coached over the duration of the study to learn how to deliver the intervention in a

manner consistent with the Pathways to Housing program model and philosophy.

People with lived experience occupied an important place in the project. Some served as peer support workers on the clinical teams. The leader and members of the peer council participated regularly on steering committee meetings. The peer council also produced an occasional project newsletter.

Study participants who were randomly assigned to TAU had access to all related services that would otherwise have been available to them had the study not been initiated. At the time of randomization,

³ See Appendix 1 for how need level was determined for each participant.

they were offered information by the study research team about other services. This was done as an ethical and humanitarian response to their immediate needs. Since the TAU group did have access to usual services available in Montréal, it is important to understand that the housing (and other) differences reported herein do not represent outcomes of a new service versus no service; instead, they represent the additional benefit of the HF model in comparison with the array of existing services that participants could access or might be offered.

The study used a randomized design in order to be able to reach unbiased conclusions about the effects of the intervention. Other designs, such as before-and-after comparisons, are subject to important biases and can only produce more tentative conclusions. Comparing the HF and TAU groups, we were able to show that the groups, for a given need level, were equivalent at the outset of the study, in terms of characteristics such as age, sex, level of functioning, homelessness history, substance use problems, mental health conditions, etc.

In the Montréal study, at the outset, MN participants assigned to HF were simultaneously also randomized either to the main HF group, with choice of scattered site apartments, or to a choice among not-for-profit community housing providers. This not-for-profit community housing group was the “third arm” offered in Montréal, but it proved necessary to abandon this experimental comparison. Only nine units were made available to our participants, and few participants who visited them favoured them over having their own apartment. In addition, some participants could not meet the criteria

for admission to some of these units.⁴ As participants assigned to this group were having to wait longer and longer for a place to stay, at the suggestion of the project’s local advisory committee, the decision was taken to simplify and offer participants a choice between having an independent apartment or entering one of the few available not-for-profit community housing units (effectively combining the original groups).

All participants were interviewed at baseline (study entry), and every three months through a complete follow-up period of 21 or 24 months. For budgetary reasons, the first 53 per cent of participants were followed for 24 months, while the remainder did their final interview at 21 months. Data collection was complete at the end of March 2013. Due to both the genuine, trusting relationships that interviewers had established with participants, and the sophisticated follow-up system that they had implemented and applied, the Montréal site achieved exceptional follow-up rates of 91 per cent overall at the final interview. Follow-up rates were almost identical between HF and TAU groups.

As was the case for other sites, qualitative interviews were conducted with a randomly selected, representative 10 per cent sub-sample of participants from all groups (HF and TAU, HN and MN) right after study entry (N=46), in order to understand the paths that led them to homelessness, as well as other aspects of their lives, such as relationships with shelters, with their families, and with social, justice, and health services. A second round of interviews, 18 months later, was conducted with the same participants (N=45, one participant

having died since the first interview), to understand what had changed in their lives since the first interview.

Other sub-studies specific to Montréal were also conducted: (a) a randomized trial of supported employment conducted among MN/HF participants; (b) a study on the impact of the HF model on participants’ families; (c) a comparison of the two ICM clinical teams; (d) a detailed examination of the perceptions of landlords, janitors, and participants with regards to housing in the Chez Soi study; and, (e) a qualitative study, which also examined the impact of peers within the clinical teams.

Participating Organizations

Several institutions in Montréal partnered to implement the Chez Soi project: the *CSSS Jeanne-Mance* established and managed the ACT team as well as one of the two ICM teams; the *Centre Hospitalier de l’Université de Montréal (CHUM)* provided psychiatrists and, later, a coordinator for the ACT team; *Diogène*, a community organization, provided the remaining ICM team; and the *Douglas Mental Health University Institute* established and managed the housing team, as well as the interviewer team. While the housing team maintained its own office, the interviewer team was located in the same offices as the *CSSS Jeanne-Mance* teams. A community-based organization that includes a large men’s shelter, but provides a variety of other services as well, *Welcome Hall Mission*, also managed the (partial) rent payments to landlords by HF participants who had given consent to their share of the rent being paid directly to their landlord out of their account.⁵

⁴ Debts are often an obstacle to being accepted by a social housing provider. Many people who are homeless also have difficulty filling out the forms needed or even providing information needed for their application to be processed. Finally, a number of social housing providers have rules (e.g., no drugs) that not all participants are prepared to meet.

⁵ Three detailed reports on implementation of Chez Soi in Montréal are available.

CHAPTER 3

PARTICIPANT CHARACTERISTICS

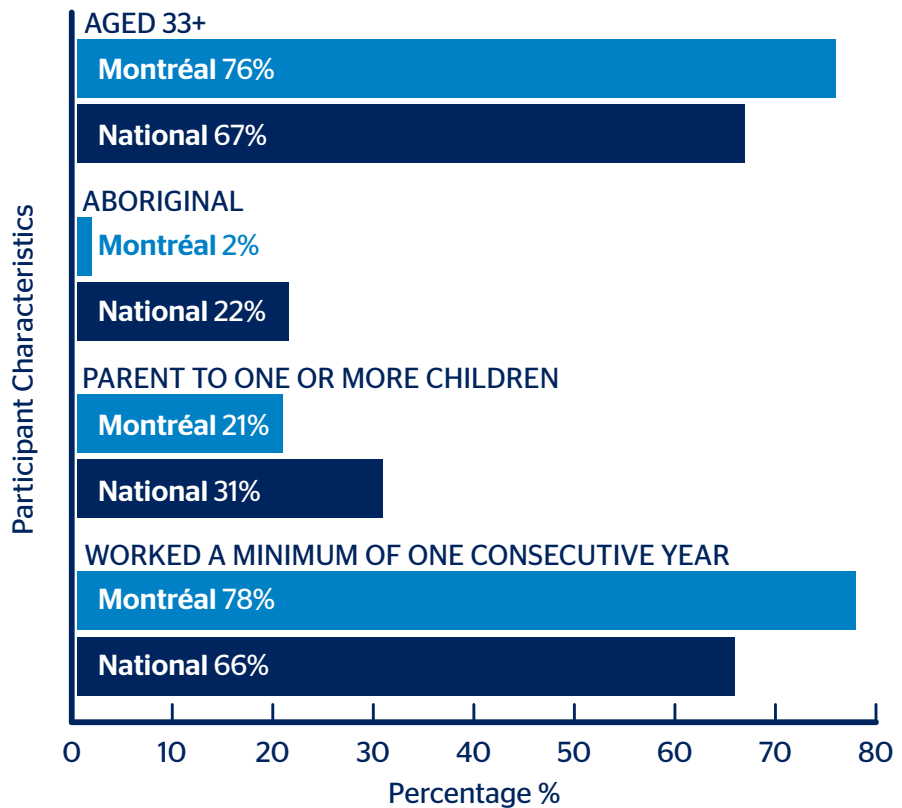
Demographics⁶

Even though eligibility criteria were identical across all sites, demographic characteristics of participants varied somewhat across the different At Home/Chez Soi sites. This reflected a combination of unavoidable small differences in recruitment methods, differences in homeless populations across cities, and the deliberate inclusion of higher proportions of some groups in some cities (e.g. Aboriginal individuals in Winnipeg). Some of the main characteristics of Montréal's participants are illustrated in Table 1.

Montréal Sample Compared to the National Sample

Compared to the national sample as a whole,⁷ Montréal participants were somewhat older: there were more participants (76 per cent) in the 33-54 and 55 year old categories than in the national sample (67 per cent). The Montréal sample included far fewer Aboriginal participants: two per cent, compared to 21.6 per cent of the national sample.

Participants in the national sample were somewhat more likely to have children (31 per cent) than those in Montréal (21 per cent). Montréal participants were slightly more likely to have more schooling than the sample as whole: 21 per cent and 30 per cent of participants said they had completed high school or any post-secondary education, compared to 19 per cent and 26 per cent. Previous employment also differed between the two samples: participants in Montréal were more likely to report that they had worked for at least one consecutive year during their life (78 per cent) than those at the national level (66 per cent).



⁶ The results of statistical tests are not reported here. This will be done in subsequent scientific publications.

⁷ Characteristics of the Canadian sample are presented in the national report. The comparisons here are with the entire sample, including Montréal, which represents about 20 per cent of the whole.

Table 1. Characteristics of Recruited Participants in Montréal

	TOTAL SAMPLE N =469 %	HN N =163 %	MN N =306 %
AGE GROUPS			
34 or younger	24	37	18
35-54	62	53	66
55 or older	14	10	16
GENDER			
Male	68	76	63
PARENT STATUS			
Any children	21	20	21
EDUCATION			
Less than high school	49	56	45
High school	21	20	22
Any post-secondary	30	25	32
PRIOR EMPLOYMENT (worked continuously at least one year in the past)	78	70	83
CURRENTLY UNEMPLOYED	94	96	94
HOMELESS STATUS AT STUDY ENTRY			
Absolutely homeless**	96	98	94
Precariously housed	4	2	6
FIRST TIME HOMELESS			
The year prior to the study 2008 or earlier	26 74	25 75	27 73
LONGEST PERIOD OF HOMELESSNESS IN MONTHS (lowest and highest rounded to next month)	29 (0-384)	37 (1-384)	25 (0-360)
TOTAL TIME HOMELESS IN LIFETIME IN MONTHS (lowest and highest rounded to nearest month)	52 (0-384)	61 (1-384)	48 (0-360)
AGE FIRST HOMELESS (lowest and highest rounded to nearest month)	35 (9-70)	31 (11-69)	37 (9-70)
DIAGNOSIS AT STUDY ENTRY			
Psychotic disorder	34	64	19
Non-psychotic disorder	60	31	74
Substance-related problems	61	76	54
HOSPITALIZED FOR A MENTAL ILLNESS ⁶ (two or more times in any one year in the past five years)	40	59	30
JUSTICE SYSTEM INVOLVEMENT (arrested > once, incarcerated or served probation in prior six months)	29	35	25
VICTIMIZATION			
Theft or threatened theft	22	24	21
Threatened with physical assault	30	30	30
Physically assaulted	28	31	27

** See <http://bmjopen.bmj.com/content/1/2/e000323.full> for definitions of absolutely homeless and precariously housed

⁶ self-report of psychotic disorders and related hospitalizations are likely to be underestimates due to the nature of the illness

Homelessness, Mental Health, and Physical Health History

Seventy-four per cent of participants reported being homeless for the first time prior to 2008, and only 26 per cent said they had been homeless for the first time the year preceding the study. Participants in Montréal experienced homelessness for the first time a bit later in their lives (age 35 on average) than the sample as a whole (age 31). Total

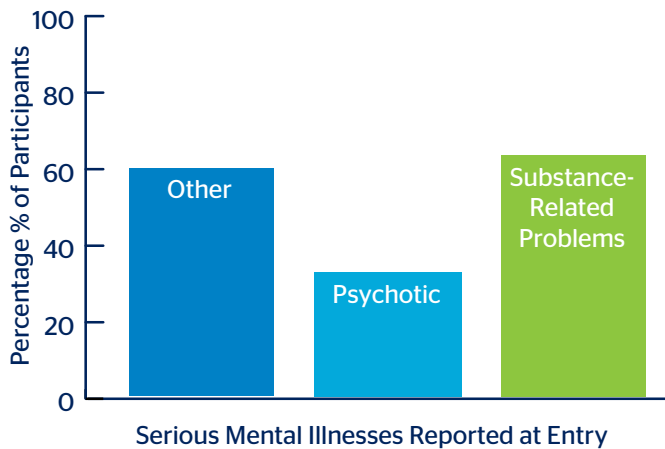
homelessness periods⁸ and longest period in the streets were also slightly shorter in Montréal (respectively 52 and 29 months), in comparison to the total Canadian sample (58 and 31 months respectively).

All participants had one or more mental illnesses, in keeping with the eligibility criteria of the study. At entry, participants reported symptoms consistent with the presence of the following mental illnesses: 34 per cent had a psychotic disorder (the same as in the national sample), 60 per cent had a non-psychotic disorder (71 per cent in national sample), and 61 per cent reported substance-related problems (67 per cent in national sample).⁹ Nearly one-third of participants (32 per cent) reported having experienced a learning problem while attending school. This percentage was slightly higher in the national sample (34 per cent). More than half of the participants in the Montréal sample (59 per cent) had a history of one or more traumatic head injuries involving unconsciousness, slightly fewer than in the national sample (66 per cent). More than 90 per cent of participants in Montréal reported at least one chronic physical health problem, about the same as in the national sample. Common serious physical health conditions include asthma (27 per cent), hepatitis C (20 per cent), chronic bronchitis/emphysema (26 per cent), epilepsy/seizures (five per cent), diabetes (nine per cent), and heart disease (11 per cent). Forty per cent of Montréal participants had two or more hospital admissions for a mental illness over the course of a one-year period in the five years before study entry.

Nearly one-third (29 per cent) of Montréal's sample reported involvement 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, which is somewhat below the rate for the national sample (36 per cent). Justice system involvement is expressed differently across sites: in Montréal, fewer participants reported having experienced victimization of one kind or another in the six months prior to study entry: 22 per cent reported being robbed or threatened to be robbed (compared to 32 per cent in the national sample), 30 per cent reported

⁸ Total homelessness is the cumulative duration of homelessness periods during an individual's life.

⁹ Statistics reported here are drawn from the MINI evaluation administered at baseline. Some participants did not score on any dimension of the MINI, but had a diagnosis of mental illness confirmed by a psychiatrist; such was the case of some participants living with a mental illness with psychotic features, but who were in denial of their symptoms. Conversely, some participants also scored positively on both the psychotic and non-psychotic symptoms sections of the MINI.



being physically threatened (compared to 43 per cent), and 28 per cent reported being physically assaulted (compared to 37 per cent). Thus, overall, criminality and victimization were lower in Montréal than in the national sample.

Differences Between Moderate Need and High Need Participants

Reflecting differences in criteria for being classified as high need (HN) or moderate need (MN),¹⁰ differences can also be noted between these groups. A much higher percentage of HN participants had a psychotic disorder at study entry (64 per cent), compared to their MN counterparts (19 per cent). Substance-related problems at study entry were also higher in the HN group (76 per cent), compared to the MN group (54 per cent). A higher percentage of HN participants were hospitalized for a mental illness at least twice in a year during the five years preceding baseline (59 per cent), compared to MN participants (30 per cent). Participants in both groups also differed in terms of homelessness history: MN participants had spent less time homeless during their lives (48 months) than HN participants (61 months), and also had, on average, shorter “longest uninterrupted periods” of homelessness: 25 months compared to 37 months. Participants in the HN groups arrived on the streets for the first time at an earlier age (31) than those in the MN group (37). They were also less likely to have worked continuously for at least one year in the past (70 per cent) than MN participants (83 per cent) and were somewhat younger on average: more HN participants were younger than 34 (37 per cent) than MN participants (18 per cent).

Observations From In-Depth Qualitative Interviews

Qualitative interviews conducted immediately following study entry shed light on participants’ lives, as well as the reasons that led them to the streets (McAll et al., 2012). Although the sample of 46 participants who took part in qualitative interviews is small, it is a representative sample,¹¹ and it is revealing to note the relative frequencies with which different patterns emerged from analysis of the transcripts. Nearly half the sample reported having experienced abuse, incest, violence, or abandonment during childhood and adolescence. Moreover, 31 per cent of the women specifically reported sexual abuse and incest during this period. Overall, 70 per cent of the participants reported negative memories when describing this part of their lives. These traumatic memories often intertwined with substance-related issues and mental illnesses in the present, which increased the risk of residential instability. Indeed, 41 per cent of the participants identified drug and alcohol use as the main reason for their being in the streets, and 80 per cent identified substance-related issues as a factor, among others, contributing to their situation. A little less than a third (28 per cent) of participants identified mental illness as the main reason for being homeless, while 11 per cent identified both substance use and mental illnesses as the main causes. Moreover, alcohol and drug use were reported to be an important challenge for many participants in the qualitative sub-sample: 89 per cent said they had suffered from a substance-related issue during their lives, while it was still an issue for 78 per cent of the sample at the time of the initial interview. Thus, mental illness, often compounded by substance use disorders, further diminished the person’s ability to maintain and develop supportive relationships. An early existential discomfort (*mal de vivre*) rooted in unsatisfactory relationships had continued into adulthood.

Ending up homeless and defining oneself as a homeless person is also viewed as an identity “shock”; in the words of a participant:

“[...] so when I went to the CLSC they referred me to, it was a shock for me. I couldn’t believe that they would send me to that place and I didn’t see any girls or any women over there, all the guys were there and I was the only woman, and I felt they think I am very homeless. I couldn’t believe it, am I really so poor that I have to come to this place, to talk to these people and I was very shocked — it’s my low point.”

¹⁰ See Appendix 1.

¹¹ Every tenth person recruited was selected for the qualitative sub-sample, with slight adjustments at the end to ensure the qualitative sub-sample had the same male/female ratio as the whole sample.

CHAPTER 4

HOUSING OUTCOMES

During the course of the study, more than 30 clinicians and housing service professionals were trained, 73 landlords and property management companies were recruited, and over 300 housing units were located and furnishings procured for them. This intensive effort had enormous direct impact on the housing circumstances of participants. In essence, homelessness was ended, at least for a time, within a few months for 276 persons in Montréal – almost all of the 285 individuals recruited to a Housing First (HF) group.

Housing Stability

In terms of outcomes after initial housing, as described in detail below, HF was unequivocally more effective than usual services in helping participants find housing and remain in stable housing most of the time during the course of the study. A substantial majority of participants maintained stable housing during the study period.

There are two ways of examining housing outcomes. The first is to compare progress over time between percentage of nights spent in stable housing for all HF and

treatment as usual (TAU) groups, for each three-month period of follow-up. As shown in Figure 1, the most dramatic difference appears during the first six months, during which HF “jumpstarts” getting housed. Over the two years of the study, participants in HF spent an average of 75 per cent of their time in stable housing compared to 29 per cent in TAU.

As shown in Figure 2, differences in housing stability were marked in both groups receiving the HF intervention (high needs/Assertive Community Treatment

The HN/TAU group never spent more than 38 per cent of their nights in stable housing at any moment during the study.

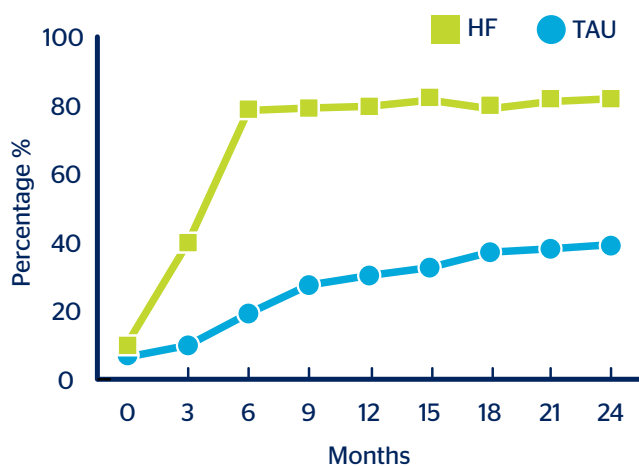


Figure 1. Percentage of nights spent in stable housing during the whole study

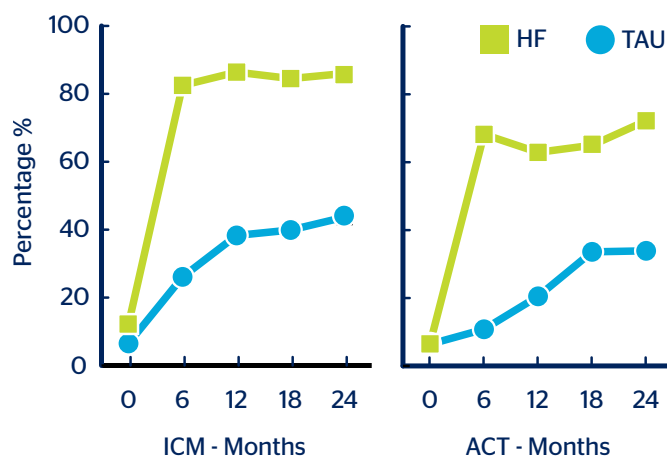


Figure 2. Percentage of nights spent in stable housing during the whole study, by need level

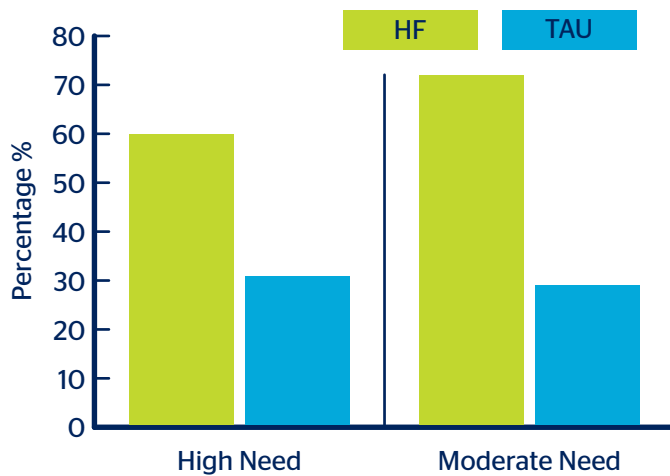


Figure 3. Percentages of participants always stably housed during the last six months

[HN/ACT] and moderate needs/Intensive Case Management [MN/ICM]). However, HN participants in the HF group spent, on average, fewer nights in stable housing¹² than MN participants in the HF group; with the exception of the first three months of the study, MN/ICM participants never spent less than 85 per cent of their nights in stable housing, whereas HN participants only reached 72 per cent of their nights in stable housing in the final three months of follow-up.¹³ HN participants receiving the HF intervention nevertheless spent on average more than twice as many nights in stable housing than their TAU counterparts. The HN/TAU group never spent more than 38 per cent of their nights in stable housing at any moment during the study.

It may be somewhat surprising to see the extent of the improvement that also occurs in the TAU groups. We attribute this to the fact that we recruited people when they were homeless and, often, in crisis. Some people who experience homelessness only experience it once in their lives; a smaller number cycle back and forth between homeless and housed periods; a smaller number still are continuously homeless. Some of the people we recruited belonged to one of the first two groups. Thus, whether using their own resources or with the help of usual services, they were able to attain stable housing again. Due to the infrequent and relatively brief contacts between interviewers and TAU participants, it seems unlikely that interviewers would have had a significant influence on outcomes for the TAU group. Finally, as previously noted, interviewers referred participants assigned to a TAU group to appropriate services immediately following group assignment. It is possible that this may have played a small role in the improvements shown by the TAU group. Any such influence only makes the contrast between outcomes for the HF and TAU groups more striking.

The progress seen in the TAU groups shows how important it was to have selected a randomized study design: we can see the difference between what participants who received HF experienced, compared to participants who received usual services. Thanks to random assignment, the HF and TAU groups at a given need level should be virtually identical at the outset in all ways that could affect housing stability.

It should be noted, too, that the comparison between HF and usual services is in a certain sense unequal. People assigned to HF, by design, experienced the concerted efforts of teams dedicated to house them and support them in their housing. People assigned to the usual services groups were left to fend for themselves amidst the wide array of available services. At the same time, though, the difference reflects the fact that usual services are not organized to help every person who is homeless, in an individualized way, to quickly attain permanent housing, and remain in it.

Housing Stability in the Last Six Months of the Study

To examine how long-lasting the effects of HF on housing stability are, we compared the percentages of participants who were always stably housed during the final six months of the study, between the HF and TAU groups, and, conversely, the percentages who were never stably housed during the same period. As shown in Figures 2 and 3, again, the effect of the HF intervention is very clear. A higher percentage of participants receiving the HF intervention were always housed during that time, both in the MN groups (72 per cent), or in the HN group (60 per cent). This was twice as high or more as their TAU counterparts in the MN group (29 per cent), and in the HN group (31 per cent). Conversely, 21 per cent of HN participants were never housed during the last

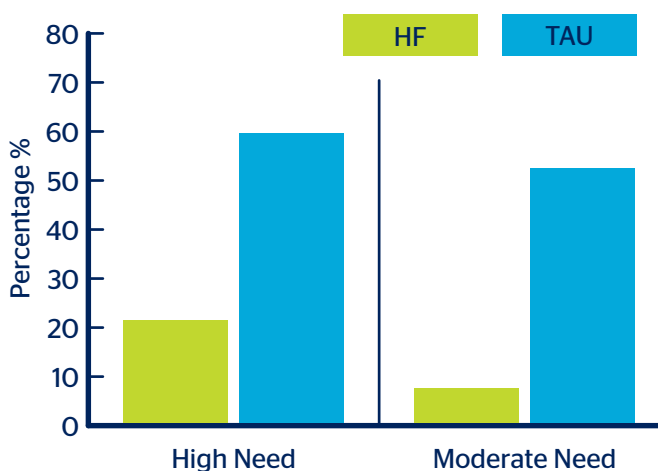


Figure 4. Percentages of participants never stably housed during the last six months

¹² Stable housing is defined as a place where participants have long-term occupation rights, such as a lease, in an autonomous setting like an apartment or room, whether on the public or private market. Rooms in rooming houses occupied for longer than six consecutive months also fit in this category, even if there is no lease.

¹³ This situation may perhaps be explained in part by the greater degree of mental illness and substance use among HN participants. But, comparing Montréal outcomes with those of other sites, it seems likely that the main reason is that in Montréal, the ACT team experienced especially great difficulties in attaining high fidelity to the HF model, difficulties which only began to resolve themselves near the end of the project.

six months of the study, compared to 59 per cent of the TAU. For participants in the MN group, only seven per cent of those receiving HF were never stably housed during the last six months of the study, compared to 52 per cent of their TAU counterparts.

Given the numbers of participants in the study, and the rigour of the study design, such large differences cannot be attributed to chance. As planned, HF services succeeded in quickly housing participants and getting them off the street. They were also very effective at helping a much greater proportion of participants remain stably housed.

Accessing Housing: From the Participants' Perspectives

Findings from the qualitative interviews highlight the importance for many participants of attaining not just stable housing, but their own place. Many HF participants spoke of the importance of “having their own place” and described their housing as a safe and secure “base” from which to move forward with their lives. Indeed, having access to stable housing (with the rent supplement provided by the project) tends to be seen as having an impact in terms of security, tranquility (“peace”), liberty, and having a space of one’s own in which one can do whatever one feels like doing – including behaving in strange ways – without being constantly in the public eye, as stated by many participants:

[...] I am calmer, more grounded; I am more inclined to live better, because now I have a place to stay. [...] my mood is better [...] I sleep more [...]. More sleep means that morale goes up. I am less inclined to become psychotic, as they say, I am less inclined to stay stuck on the same problem. Now if there's something I don't like, it's like a TV channel, if I don't like the TV channel, I change it [laughs]!

And also, in an apartment, let's say you're angry, you can talk to yourself. You can talk to yourself all alone when you have your own place. Something happened to me. I talked to myself for a half-hour. But when you're in front of others, you don't do that. People will think you're nuts. [...] What I like is that you're by yourself. You're at your own place. People leave you alone. You are serene. If you want to listen to music or TV – it's up to you. If you want to eat at a certain time, you can eat at that time. You want to wash up at a certain time, you can decide to wash up at that time. You do what you want to.

I can say that finally I am able to pay my rent, and also I like, I really love my apartment...even if the floors are not very nice [small laugh], I really love my apartment. I've got room, I have a cat, and that, that brings me a lot of happiness. [...] Now I have the freedom to do all these tasks when I feel like it.⁴

Additional interviews carried out in the context of the Montréal housing sub-study also suggest that the apartment allowed the participant to develop a greater sense of security and stability, based on two dimensions: protection of one’s private life, and the appropriation of a living space, a place that the participant can decorate and arrange in a way that expresses and affirms their identity (Dorvil & Boucher Guèvremont, 2013).

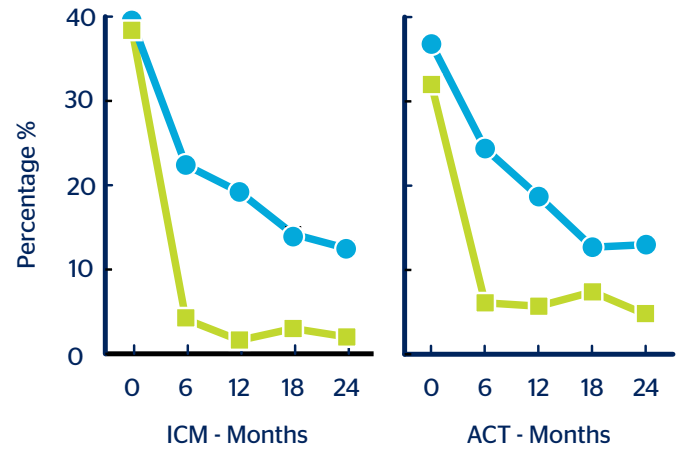


Figure 5. Percentage of days in emergency shelters

Time Spent in Emergency Shelters and Institutions

As a consequence of nights spent in stable housing, nights spent on the street or in shelters by HF participants also fell dramatically, to a greater extent than for the TAU group. As mentioned earlier, the percentage of nights spent in stable residences also increased for the TAU groups. However, as illustrated in Figures 5 and 6, their time was spent in temporary housing, shelters, and streets to a greater extent than for the HF groups.

Participants in the MN group, whether they were in the HF or TAU group, spent, on average, nearly the same, fairly limited, amount of time in institutions (hospital, prison, penitentiary, drug treatment facility, etc.). In contrast, the intervention had a more dramatic effect on HN participants: participants in the HN/ACT never spent more than 15 per cent of their time in institutions during the study, while this number was 30 per cent for HN/TAU. It is possible that, because of very high or urgent mental health needs and substance-related problems, TAU participants had to depend on institutions for care.

Landlord Engagement

The HF model implemented in At Home/Chez Soi, as previously described, emphasizes client choice and thus, as a rule, seeks units from private housing sector landlords. Feasibility and effectiveness of the model depend on being able to recruit landlords and keep them engaged. Based on interviews with eight landlords and four janitors, we found that the majority of landlords and janitors interviewed had previous experience with tenants who share similar characteristics with the Chez Soi tenants: substance use, mental illness, etc. They did not have a negative bias toward them; rather, they demonstrated empathy toward them and were favourable to projects that help people in these circumstances. In their eyes, the Chez Soi participants were regular tenants, like others. Landlords who had not had prior experience with people sharing similar characteristics to the Chez Soi participants tended to view them as different from their “regular” tenants. One landlord

¹⁴ The three quotes above, as well as all subsequent quotes in this report, are translated from French.

indicated that the only difference from her other tenants was that the participant behaved in a way she was not accustomed to:

The only one, is the one I was talking about earlier, who in terms of her behaviour was a bit different from the others. That's the only moment that I saw a difference. Sometimes she had the impression that everyone in the building was against her and that wasn't the case. I don't know that participant's diagnosis.

Landlords and superintendents, even if they sometimes provided small services to the Chez Soi participants (e.g., lending a small sum of money, helping them maintain their apartment), categorically refused to play the role of the project staff; it was up to project staff, in their view, to deal with participants during crises or very difficult situations. On this subject, landlords and superintendents were generally satisfied with the involvement of the clinical teams, but some of them would have liked to collaborate more closely, sharing their observations of the participants concerning many significant dimensions of their lives: their behaviour, general appearance and personal hygiene, the condition of the apartment, the people they invited to their place, etc.

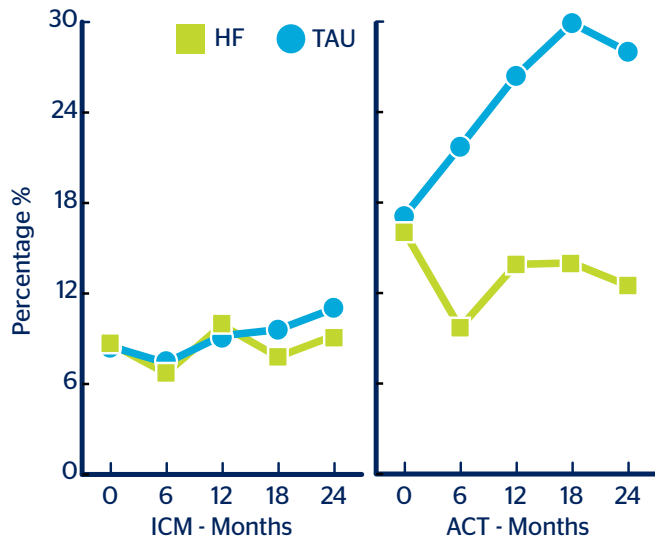


Figure 6. Percentage of days in institutions during the whole study

CHAPTER 5

SERVICE USE AND COST OUTCOMES

ER Services, Outpatient Visits, and Drop-in Services

An important advantage of stable housing for individuals with mental and physical illness is the possibility of shifting their care from institutions and crisis-related services to more appropriate, planned visits and regular follow-up with community-based services. During study follow-ups, participants were asked about all the types of health, social, and justice services they had accessed. Some desirable patterns in the types of health and social services used during the day were found and are illustrated for both need groups in the figures below. Both Housing First (HF) and treatment as usual (TAU) groups (combining high need [HN] and moderate need [MN] participants) reported declines in emergency room (ER) visits (Figure 7), with generally lower levels among HF participants after study entry. HF participants also reported far fewer visits to hospitals for outpatient care,¹⁵ as shown in Figure 8. This difference maintained itself over the entire research period.

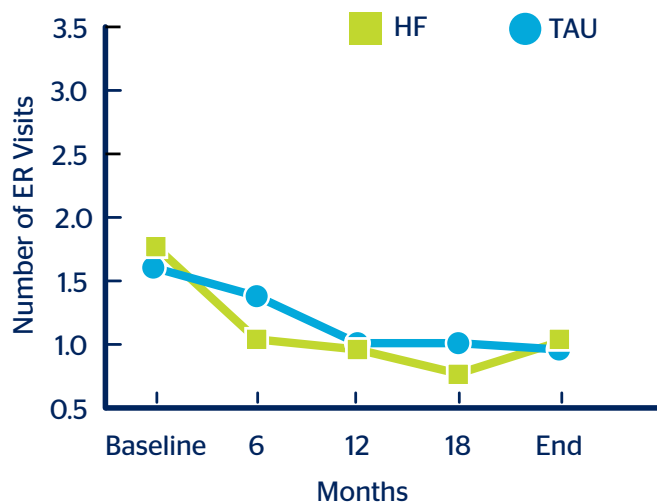


Figure 7. Emergency room visits

Use of drop-in centres for meals and other services provided to individuals in need was lower, on average, for the HF group at baseline (which can only be attributed to chance) and remained so throughout the study (Figure 9). In contrast, use of food banks increased for HF participants. This is not surprising given that many food banks require a fixed address in order to provide a hamper, and generally provide goods that need to be stored and prepared in a kitchen equipped with basic appliances. Contributing to this as well, the income of the vast majority of participants was limited to modest welfare or disability payments. Qualitative interviews revealed that having a home and a place to put things enabled some to discover (or rediscover) the art of cooking, buying groceries, and leading what several describe as a “normal” life, in spite of the financial restrictions under which they were operating.

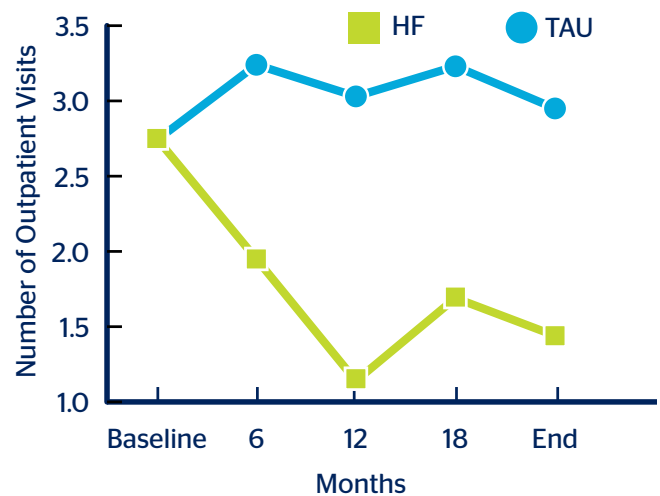


Figure 8. Outpatient visits

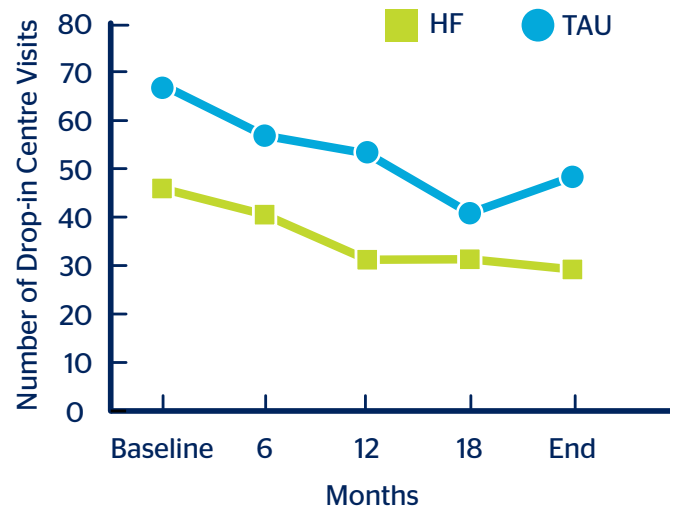


Figure 9. Drop-in Centre Visits

¹⁵ These included day hospital visits but not visits for laboratory or diagnostic tests.

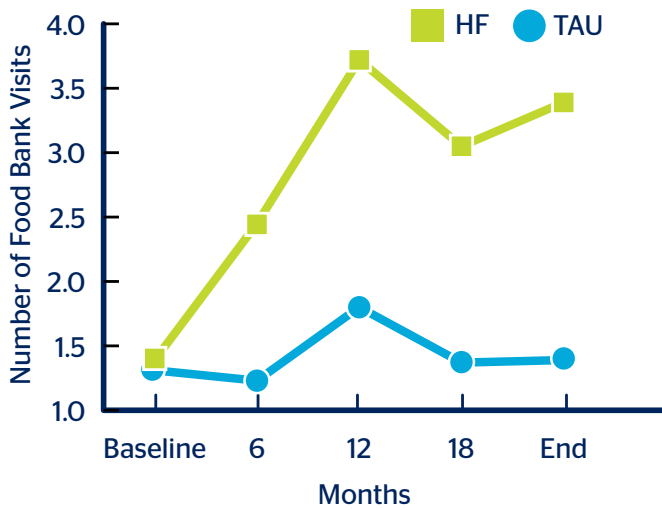


Figure 10. Food Bank Visits

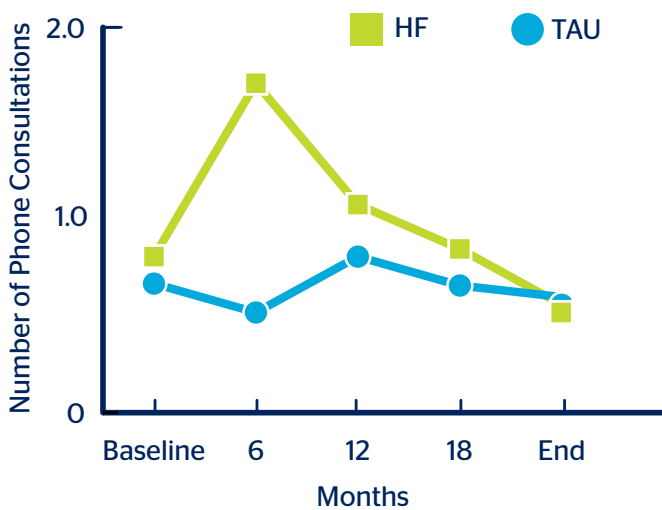


Figure 11. Phone consultations with providers

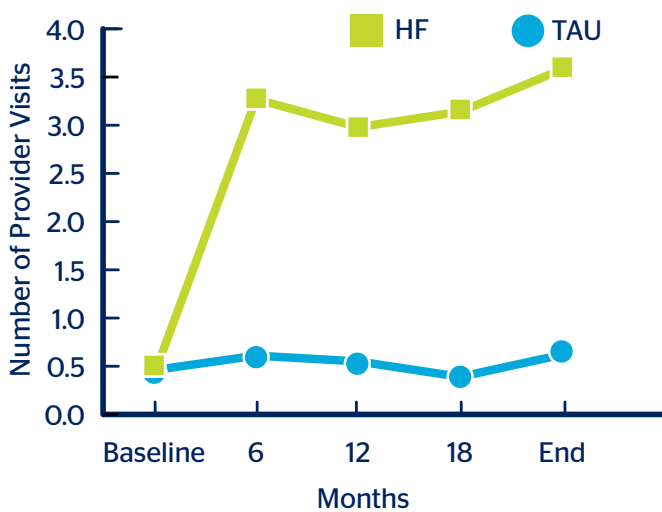


Figure 12. Provider visits

Not surprisingly, both phone consultations with service providers and provider visits increased for HF participants during the study, and can in all likelihood be attributed to clinical teams from the Chez Soi project (Figures 11 and 12). Phone consultations peaked at six months, and decreased regularly during the study, to reach nearly the same level as TAU participants after 24 months. Provider visits increased significantly for HF participants, since one of the conditions for HF participants in the project was to meet at least once per week with HF program staff.

Justice Service Use and Victimization

In initial descriptive analysis, few differences emerged between HF and TAU participants in terms of involvement with the justice system or victimization. Both groups experienced decreases in criminal justice involvement and victimization over the course of the study, but no differences were noted in terms of contacts with police without an arrest, arrests, police detentions, court appearances, or incarcerations. For HN participants only, HF was associated with a somewhat greater reduction in charges laid compared to the TAU group, and with greater reductions in victimization from assaults. The percentage of HN participants in the HF group who were accused of or a victim of assault declined during the course of the study.

Cost Analysis

We evaluated the economic impact of the HF programs, considering all costs incurred by participants: those of health, social, and justice services, such as hospitalizations, shelters, and police arrests, as well as the costs of welfare and disability benefits. (Additional information on the methods used is provided in Appendix 3.) The intervention cost \$22,482 per person per year on average for HN-ACT participants and \$14,029 per person per year for MN-ICM participants. These costs included salaries of all front-line staff and their supervisors; additional program expenses such as travel, rent, utilities, etc.; and rent supplements provided by the MHCC grant. The intervention for HN participants is more costly because, while the ICM team, as implemented in At Home/Chez Soi, includes one case manager for every 17 participants, an ACT team includes one case manager for every 10 participants.

Over the two-year period of the study, by comparing the costs of services incurred by participants who received HF services with those of participants who received usual services, and by taking into account differences in costs that existed between the groups at study entry, we estimated that every \$10 invested in HF services resulted in average reductions in costs of other services of \$8.27 for HN participants and \$7.19 for MN participants.¹⁶

As may be noted from the Figures 13 and 14, TAU participants, whether HN or MN, also experienced reductions in costs after baseline. This is analogous, and related, to the experience of TAU participants with respect to housing stability and other variables. People tended to be recruited to the study during periods when they were homeless and doing relatively poorly; TAU participants experienced a certain improvement, on average, after they were

¹⁶ These offsets are obtained by calculating the ratio of the difference in the reduction of non-HF costs between HF and TAU (i.e., annualized baseline minus subsequent annualized non-HF costs for the HF group, per person, minus the same for the TAU group) to the annualized cost of the HF intervention per participant. This "difference-of-differences" method allows us to take into account any differences in baseline costs between the HF and TAU groups.

recruited, thanks also to available services. This is reflected in a reduction in costs over the two years following study entry. While both groups experienced a reduction in costs, the reduction in the costs of services other than the intervention itself, which is represented by the darker green portion of the bars in the figures, is greater for the HF groups. Total costs avoided arise from a combination of decreases in the costs of some services (cost offsets), and, to a much smaller extent, increases in the costs of certain others.

Thus, as illustrated in Figure 13, HN-TAU participants used, on average, the equivalent of \$69,072 in various services per year before baseline, while HN-HF used \$68,176. The corresponding numbers were \$52,660 for MN-TAU and \$51,386 for MN-HF at baseline. These differences are not statistically significant and must be interpreted as being due to chance, since participants were randomized at baseline and were not yet receiving HF services. Between 0 and 24 months, average annualized costs per participant, including the HF intervention (light green bar), dropped to \$64,655 per person per year for HN-TAU participants and to \$67,652 for participants receiving HF services. The same phenomenon can be observed with MN participants, in Figure 14 below: as previously stated, the average annualized cost at baseline per MN-TAU participant is slightly higher (\$52,660) than for the MN-HF (\$51,386). Between 0 and 24 months, the annualized average costs per MN-TAU participants diminished to \$42,373, while MN-HF costs per participant decreased to \$45,046. A large part of the cost of the HF intervention is offset by a reduction in the costs of other services.^{17,18}

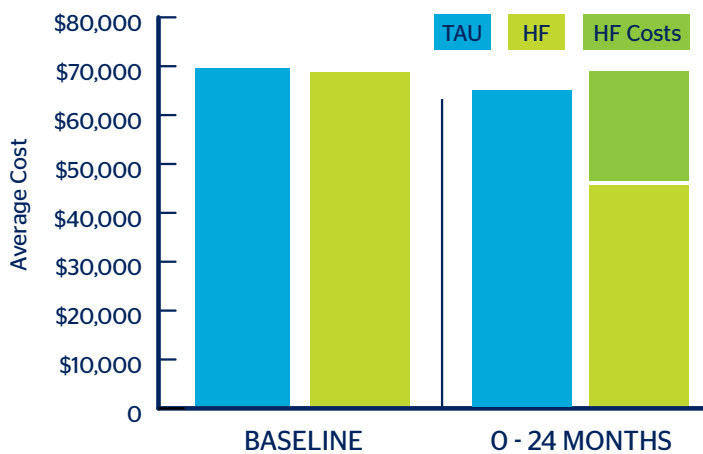


Figure 13. Annualized average costs per person for HN participants, by experimental group, baseline vs experimental study period

Cost Offsets

Cost offsets, or compensatory reductions in costs associated with receiving HF, along with cost increases, are illustrated in Figures 15 and 16.¹⁹ In these figures, all cost offsets or spending increases greater than \$1,000 are shown. Offsets are represented by the green bars, while spending increases are represented by blue bars. As Figure 15 illustrates, the greatest cost offset for HN participants is psychiatric hospitalizations: on average, participation in HF resulted in an estimated reduction of about \$14,003 in inpatient stays. The costs of the HF intervention, which includes psychiatrists and nurses for HN participants, have thus partially replaced the costs of inpatient stays. As may be seen, the HF intervention also caused comparatively small increases in the costs of attendance at day centres, nights in psychiatric residential programs, and non-study office-visits. It is possible that, as participants who received the HF intervention spent fewer days in psychiatric hospitals, they therefore used more services outside, such as day centres, or other health and social professionals, or accessed some housing programs addressing their specific needs, such as psychiatric residential programs.

For MN participants receiving HF, cost offsets illustrated in Figure 16 arose from differences in use of single room occupancy (SRO) residences with support, emergency shelters, social housing, and crisis housing. In contrast to the situation with HN participants, the figure shows that psychiatric hospitalizations were somewhat increased. ICM teams do not include any medical personnel. It is possible that case managers on ICM teams facilitated participants'

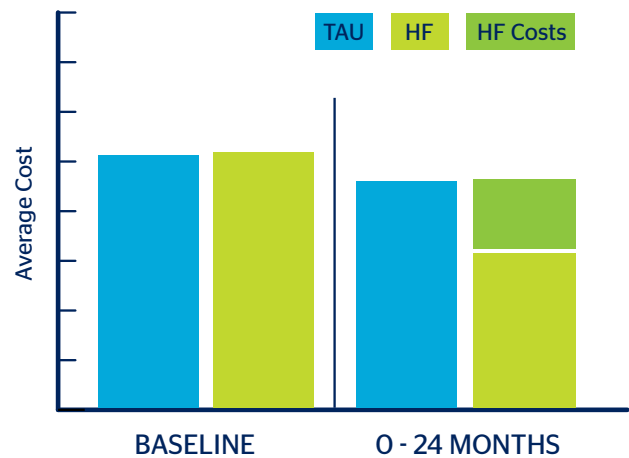


Figure 14. Annualized average costs per person for MN participants, by experimental group, baseline vs experimental study period

¹⁷ At the time this report was produced, we had very recently received data from the government of Québec on the costs of medications. Preliminary analyses suggest that the intervention increased costs by about \$770 per participant per year for HN-ACT participants, while it reduced them by about \$915 per participant per year for MN-ICM participants. The increase for HN-ACT participants is likely attributable to the fact that HN participants have severe mental illness, and the ACT team supports the taking of psychiatric medications. Additional analyses are required to further explore and confirm these results.

¹⁸ A formal cost-effectiveness analysis is in preparation and will be reported in a scientific publication.

¹⁹ Cost offsets for specific services were also calculated using a "difference-of-differences" method. That is, we calculated for both the HF and TAU groups, the difference between the annualized baseline and subsequent (0-24 months) costs of a specific service, such as psychiatric hospitalization, and then we calculated the difference between these two differences (HF - TAU). Thus, a positive result indicates that there was a greater reduction (or, it may be, a smaller increase) in the HF than in the TAU group.

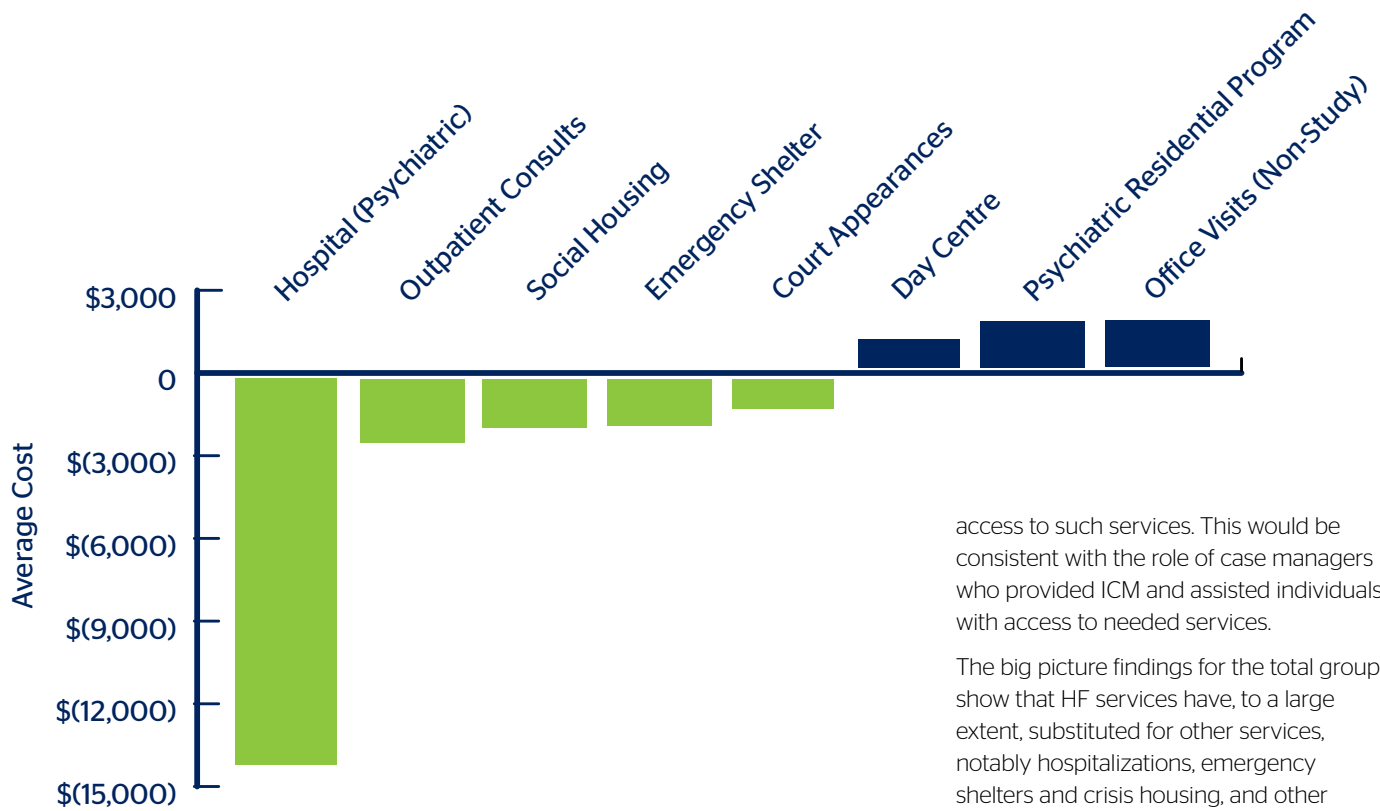


Figure 15. Annualized average cost offsets per person for HN participants

access to such services. This would be consistent with the role of case managers who provided ICM and assisted individuals with access to needed services.

The big picture findings for the total group show that HF services have, to a large extent, substituted for other services, notably hospitalizations, emergency shelters and crisis housing, and other types of housing with supports. Because of the permanent housing and the support services that the HF intervention made available to them, HF participants needed fewer other services. Overall, the intervention came close to paying for itself. That the intervention did not *more than* pay for itself should not be surprising, as people were recruited to the study on the basis of need, not on the basis of the costs they had incurred. As a result, some of the people recruited were living in parks, under bridges, etc., avoiding shelters and other services as much as they could, so that they had cost little or nothing in the months preceding their entry into the study.

It should be noted that “paying for itself” in this context does not mean that a government that paid for HF services would see a corresponding reduction in its expenditures on other services. There are at least three reasons for this. First, if, for example, HF prevents an individual from being hospitalized, the hospital bed that this person does not occupy will almost inevitably, given occupancy rates of Québec hospitals, be filled by another patient, and the hospital may see no difference in its expenditures. Nonetheless, a costly resource has been freed, which benefits another patient: the gap between available supply and demand has been

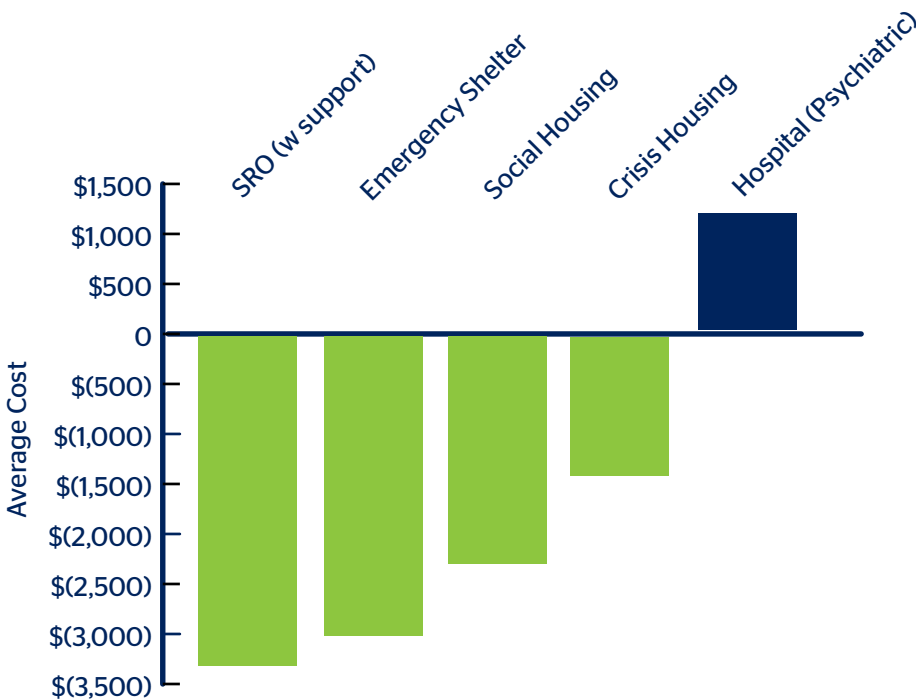


Figure 16. Annualized average cost offsets and increases per person for MN participants

decreased slightly. Second, we estimated the costs of individual services taking into account not just the portion of costs borne by governments, but also that covered by private donations and even some volunteering, when essential to the delivery of the service, particularly for emergency shelters. Thus, a reduction in use of emergency shelters would translate partly into a reduced need for government funding, but also into a reduced need for private donations and volunteering. Third, while the great majority of the avoided costs that we have documented are borne by the provincial government (though by different ministries, such as justice and health and social services), others are borne at least in part by municipal governments (community-based housing and front-line services), and others by the federal government (federal penitentiaries).

The fact that the intervention does not, on average, pay for itself should not be interpreted in a negative light. Few innovative health care technologies that governments agree to fund pay for themselves: often, they generate no cost offset at all. Rather, they are judged to yield

sufficient benefit to merit their cost. In many cases, observers have commented that the benefits of interventions that governments agree to fund can seem quite modest in relation to the costs: for example, some end-of-life cancer drugs may increase terminally ill patients' life expectancy by a matter of weeks or a few months at most, with poor quality of life, at costs in the tens of thousands of dollars per patient. In this view, the net cost of HF is very modest in relation to the benefits that it clearly generates for one of the most disadvantaged and marginalized groups in our society. (These benefits are further described in the next section.) In this context, it is important to note that some of the recipients of HF had been disengaged from health and social services and were consuming very little of any services. As a result, these individuals used more services of many kinds, in addition to HF, but this outcome can be viewed as positive. For example, one participant in Montréal was discovered to have untreated hepatitis C and, as a result of advocacy from his HF team, received interferon B therapy, which cured him of the disease.

Finally, it should be noted that our economic analysis was carried out over a horizon of only two years. As described in the next section, the trajectories of participants in the HF groups suggest that, had we been able to follow participants for a longer period, many would have become more stabilized, and a number may also have returned to work. The net cost of the intervention would then have been further reduced, and it is possible that a long-run analysis would show HF to more than pay for itself over time. Further research is needed to ascertain whether this is indeed the case. The Montreal research team will continue to follow participants for an additional two years and this research will provide additional evidence with respect to the longer term impacts of Housing First.

CHAPTER 6

SOCIAL AND HEALTH OUTCOMES

As mentioned earlier, interviewers met the participants of both groups at study entry and, at a minimum, six-month intervals to ascertain how they were doing on a wide variety of dimensions. (The full list of questionnaires and their schedule of administration are in Appendix 2). The general pattern we observed from these quantitative measures is one of improvement in both Housing First (HF) and treatment as usual (TAU) groups, with some additional benefit for HF participants on two measures.

Quality of Life and Community Functioning

Over the 24-month study period, the effects of the intervention on quality of life and community functioning were measured. Quality of life was measured with the Quality of Life Index (QOLI-20), which asks about satisfaction with family relationships, finances, leisure, living situation, and safety. In addition, to assess community functioning, the Multnomah Community Ability Scale (MCAS) was used. This is a 17-item scale that covers aspects of functioning such as the level of difficulty with mental and physical health, ability to cope with illness, social skills, drugs and alcohol use, and problem behaviours. While the QOLI-20 consists of questions answered by participants, the MCAS is completed by the interviewer, based on observed behaviour and responses to previous questionnaires. This approach was taken to ensure that outcomes reflected both participants' perspectives and "objective" ratings by study research staff (i.e., interviewers).

As Figures 17 and 18 show, for both high need (HN) and moderate need (MN) participants, community functioning increased from zero to six months, but then decreased over the follow-up period, ending somewhat above the baseline level for HN participants, but

not for MN participants. However, functioning increased more for both HN and MN/HF participants. While this is encouraging, the effect of HF appears modest.

Figures 19 and 20 describe, in an analogous way, the evolution of quality of life scores. On this measure, HF appears to have been more effective among MN than HN participants. In the case of the former, quality of life increased steadily for HF participants while, in the TAU group, it rose and then fell. The difference between the two trajectories is such that, given the number of participants included in the comparison, it is highly unlikely to be due to chance. For HF participants, on the other hand, there is no significant difference in trajectories.

We did not observe any differences between HF and TAU groups on any of the other measures that we tested: a measure of the problems associated with substance misuse, or physical or mental health scales. Thus, overall, considering the results obtained with the functioning and quality-of-life scale, the quantitative measures suggest that HF has been beneficial for participants, particularly for those classified as moderate need.²⁰

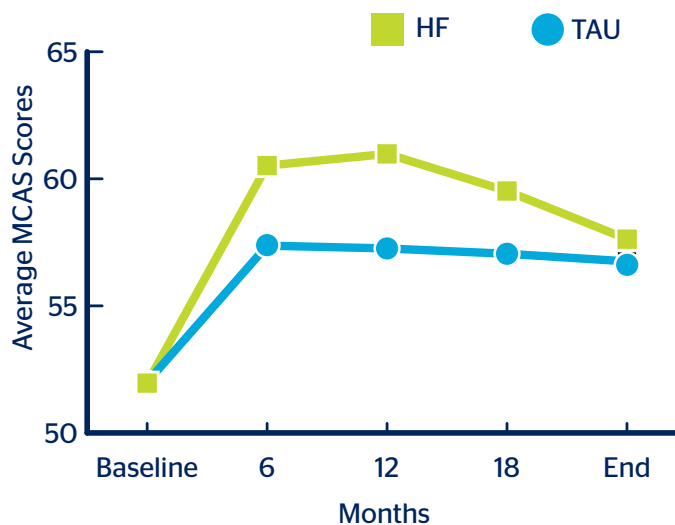


Figure 17. Community functioning, HN participants

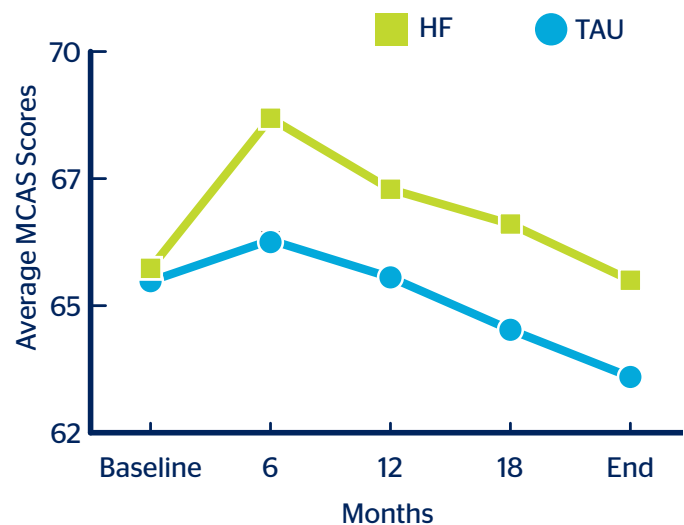


Figure 18. Community functioning, MN participants

²⁰ These relatively small differences between the groups contrast markedly with the findings from the qualitative analyses described subsequently. It may be that the duration of the study was too short for significant differences to be detectable on most of our measures.

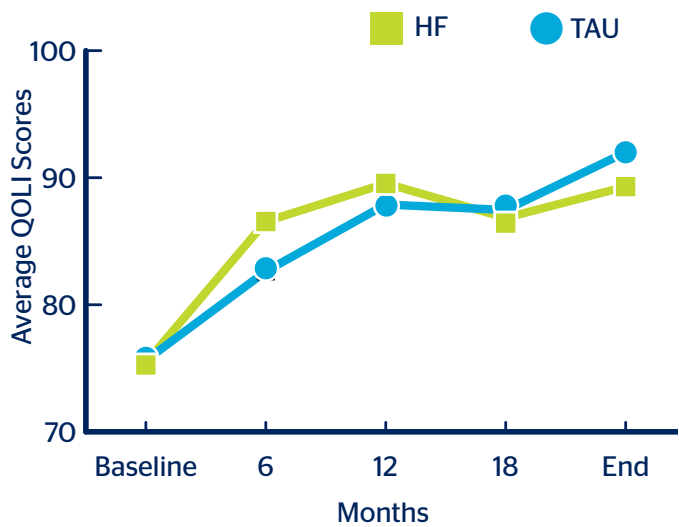


Figure 19. Quality of life, HN participants

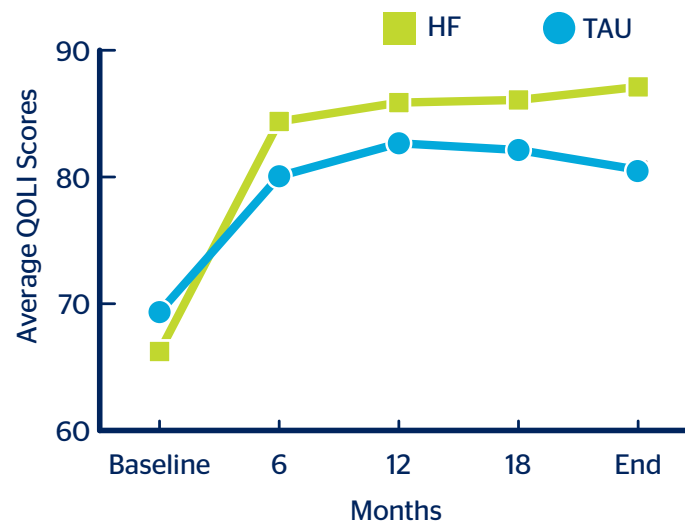


Figure 20. Quality of life, MN participants

Participants' Perspectives: 18 Months After Study Entry

A second set of narrative interviews was conducted on 45 of the original 46 participants who were randomly selected for a qualitative interview, about 18 months after study entry (McAll et al., 2013). The purpose of this set of interviews was to examine and understand possible differences between the two groups over the course of the study. In contrast with the quantitative measures, the qualitative data suggest more substantial differences between the HF and TAU groups. Wellbeing, defined as a sense of “peace,” “security,” and the ability to live at their own “rhythm,” is a feeling that participants in the HF groups were more likely to mention in the 18-month interviews. As stated by one participant:

I've become more calm, less nervous, less anxious, if you will. Yep. Less stressed, in terms of always being afraid of what tomorrow will bring. [...] When you're on the street, you're, you're afraid of tomorrow, what's going to happen tomorrow, how am I going to manage. So [...] that, that did some good. I mean, to know that in one month, in two months, in three months, well, you'll still be in the same place, you know.

Participants not only declared feeling “at home,” but expressed the need to protect their private life, and to be more selective about who is allowed to cross their doorstep. The acquisition of a home allowed participants to experience a kind of positive withdrawal into themselves. This withdrawal appears as an opening onto a new ‘space-time’, devoted to rest and recovery” (Dorvil & Boucher Guèvremont, 2013).

Relatedly, members of the experimental groups were also more likely to say in interviews that they felt less stressed (15 per cent express this opinion as opposed to no one in the TAU groups), while members of the TAU groups were three times more likely to say that their stress level had increased (18 per cent being of this opinion).²¹

The effects of the HF intervention are also revealed by what participants brought up during the interviews. For example, HF participants were three times as likely as those in TAU to mention in the interview that their mental health had improved over

the 18 months (33 per cent expressing this opinion), while TAU participants were more than twice as likely to say that they had contemplated suicide over the same period (24 per cent). HF participants were also four times as likely to say that they had reduced their consumption of prescription medicines (22 per cent expressing this view), while TAU participants were four times as likely to say that their physical health had deteriorated over the period (47 per cent being of this opinion). As for drugs and alcohol use, HF participants were twice as likely to say that they had reduced consumption (30 per cent expressing this view), while TAU participants were more than twice as likely to say that their dependency on drugs and alcohol had remained the same or increased (47 per cent). HF participants also often explained why the intervention had resulted in these positive changes. For example, the stability and security of being in their own apartment reduced the need to self-medicate using alcohol or drugs.

The increased self-confidence expressed by HF participants tends to be associated with making their own decisions. (Recall that participant choice, in the way the HF intervention is delivered, and in the goals that participants will pursue with the support of HF staff, is a central feature of the Pathways version of Housing First.) Many were somewhat surprised at the degree of responsibility required of them by the project. In the interviews, 22 per cent attached value to what they saw as a new-found feeling of liberty or autonomy that had developed over the period, as a consequence, in part, of that responsibility. This is in sharp distinction with TAU participants, none of whom mentioned any such comparable feeling of liberty or autonomy as having been part of their experience over the 18-month period. In contrast, some HF participants expressed the opposite view in the same proportion, with 22 per cent placing an emphasis on their being subject to petty rules and regulations relating to personal behaviour, access to and use of services, presence in public spaces, or other aspects of their daily lives. One participant's complaints about the lady running his boarding house are not atypical:

²¹ As with the first set of narrative interviews, we report the percentages of participants in each group who expressed one type of opinion or another. Due to the small sample sizes, individual percentages are subject to considerable sampling variation. Readers are invited to note the overall pattern that emerges, rather than lay much weight on individual percentages.

So all this control that she's doing [...] I can't wear my shoes in the house. I have to pay money if I come in the house after the curfew, pay for the lock. If I have the police call the house, I have to pay \$150. If I'm out of the house for 24 hours, I have to call and report and tell her where I'm going and tell her where I'm coming from. All these things that she's doing [...] it's not normal. When you pay your rent, you have the ability to go in and come out if you want.

While one in four HF participants expressed feelings of solitude, others mentioned the new friendships that they had managed to make over the 18 months. It must be mentioned, however, that one in four participants of the TAU group also expressed feelings of solitude. This suggests that, contrary to what one might expect given that HF participants most often move into independent scattered site apartments in new neighbourhoods, HF may not, in fact, increase such feelings. Furthermore, HF participants were five times as likely as TAU participants to say that they had made new friendships, with 33 per cent expressing this opinion. These new friends could have been encountered in social activities or may have been neighbours living in the same apartment building. The fact of having one's own home in which friends could be welcomed was seen as a contributing factor to the building of friendships. HF participants were also six times more likely than TAU participants to say they had reconnected with family members they had not been in contact with for some time, with 37 per cent mentioning this type of reconnection as a central and positive aspect of their experience over the previous 18 months.

A preliminary analysis of the subjects that participants raised in the interviews revealed 24 different dimensions according to which participants may have experienced a positive, negative, or mixed/neutral trajectory (path) over the course of the project, whether in relation to study entry (e.g., improvement or worsening in physical health), or simply on its own (e.g., having experienced suicidal thoughts). On the basis of these dimensions, participant trajectories were evaluated as being positive, neutral, or negative. Analyzing the interviews in the same way for HF and TAU participants suggests little difference between the HF and TAU groups among HN participants, but more substantial differences between HF and TAU groups among MN participants:

- Of the eight HN participants receiving HF who were interviewed, three had negative trajectories, two had neutral trajectories, and three had positive trajectories.
- Of the eight HN participants interviewed that were assigned to TAU, four had negative trajectories, one had a neutral trajectory, and three had positive trajectories.
- Of 19 MN participants assigned to HF, 16 described positive trajectories and only three described negative trajectories.
- Of 10 MN participants assigned to the TAU groups, eight had negative trajectories, and only two had positive ones.

The analysis of these interviews also helps our understanding of why HF was not always successful: recall that according to data presented earlier, 21 per cent of HN participants, and seven per cent of MN participants in the HF groups, were not housed stably at all during the final six months of follow-up. In some cases, this was due to prolonged incarceration or hospitalization. However, the qualitative interviews reveal three other types of situations

in which the intervention, as implemented, was insufficient. One female respondent in the high needs group (ACT) evaluated her initial involvement in the project positively (with respect to housing, for example), but, subsequently, an abusive brother caught up with her and made her life miserable:

I feel like taking all the medication, then, then to just decide to screw it all, take all of the medication, drink and then never wake up.

Two similar cases involve women who had suffered long-term abuse or violence, either from childhood or at the hands of a spouse over a number of years. Both expressed appreciation for the support of the Chez Soi teams, but their past experience weighed heavily throughout their account of the 18-month period, notably in terms of depression, anxiety, fear, and continuing negative family relationships. They mentioned few positive outcomes. Finally, two men seemed to have remained subject to the same mental health issues that predominated at study entry: their worlds were strongly marked by paranoid thoughts and feelings, which they projected to the ACT and ICM teams. Again, almost no positive outcomes were mentioned, although one of the two seemed to appreciate the fact of being housed.

In contrast, the one individual in the TAU group who had a positive trajectory is someone who had a mental illness that was diagnosed and treated appropriately at the beginning of the project.

To What do HF Participants Attribute the Success of the Intervention?

Finally, to what do the participants themselves attribute the success of the HF intervention? Four factors stand out: rapid access to stable housing, intensive long-term support by ACT and ICM teams, a non-judgmental attitude on the part of case managers, and regaining responsibility for decision making. In other words, participants in the HF groups stressed the importance of the clinical teams, who, by their continued, non-judgmental, and regular support, and by encouraging participants to make their own decisions, helped them to overcome the challenges of living in an apartment and make progress toward their own goals.

It is interesting to note that in the narrative interviews at study entry, 32 per cent of named organizations were described positively by participants, often for similar reasons that HF programs were valued. Even in the absence of HF services, this suggests that at least some of the organizations currently serving people who are homeless – mentioned at the beginning of this report – would be more positively appreciated if they were to emulate these characteristics in their interactions with people experiencing homelessness.

At the same time, the results suggest that organizing services according to the HF model, as was done in the Chez Soi project, appears to be an effective means of concentrating these positive attributes into a package that helps the majority of participants begin to move along a positive trajectory. Furthermore, it is important to note that participants' perspectives on what made the intervention effective cannot tell the whole story: of necessity, they could not see the whole of what had been put in place and was happening on a day-to-day basis to help them. We will return to this in the final section.

CHAPTER 7

RESULTS OF OTHER STUDIES SPECIFIC TO MONTRÉAL

In addition to the main analyses, several studies were conducted in Montréal. One, which aimed to describe the network of services available to people who are homeless in Montréal, received brief mention in the first section of this report. Some key findings from a study on experiences of landlords, janitors, and participants, with respect to housing, have also been previously described. In this section, we briefly summarize the remaining studies, those for which key results can be reported at this time.²²

Randomized Trial of Supported Employment

A randomized trial of the Individual Placement and Support (IPS) model of supported employment was conducted to determine if supported employment services could effectively help Intensive Case Management (ICM) participants who expressed a desire to work, to find and keep competitive jobs. IPS is well established as an evidence-based practice for people with mental illness in general. It is analogous to Housing First (HF), with choice of competitive job replacing choice of housing. However, little is known about its effectiveness with people with mental illness who have recently been homeless and are being served by a HF program.

Recently housed moderate needs (MN) participants could choose, during the first 12 months following baseline, to participate in the IPS sub-study. In total, 45 participants were randomly assigned to IPS services and 45 to a comparison group who received whatever vocational services their HF team could provide or refer them to. In addition, semi-structured interviews were conducted with 14 IPS participants and

13 comparison group participants. When fully staffed, IPS services were offered by a team of two workers supervised by an experienced specialist from the Douglas Mental Health University Institute.

In brief, the IPS intervention did not prove successful in improving employment outcomes. Thirty-four percent of participants receiving IPS supported employment obtained competitive employment, compared to 22 per cent of the comparison group. The difference, however, was not statistically significant. The qualitative interviews suggested that study participants experienced several barriers to returning to employment: continued substance use, having a criminal record, stigma about mental illness, and self-stigmatizing beliefs about self-worth. Participants receiving IPS services were more likely to develop trusting relationships with service providers, a development inhibited by their experiences of homelessness. Trusting relationships helped participants collaborate with IPS workers to facilitate

their search for work. IPS participants had higher satisfaction with services and more often spoke of rewarding experiences in employment. They also recognized the progress they achieved toward their employment goals.

Significant difficulties in recruiting and retaining individuals with the qualities needed to be effective employment specialists with this population also inhibited success. Full staffing with a good level of fidelity to the IPS model was attained only for a period of less than one year. Had implementation been carried out in the context of a permanent program, qualitative findings suggest that the results would have been more favourable to IPS. In addition, analysis of employment rates across all the groups in At Home/Chez Soi suggests that the IPS study may have motivated ICM case managers to play a more active role than they otherwise would have in helping non-IPS participants find work: the Montréal MN-ICM groups as a whole exhibited relatively high employment rates.

Outcomes of the HF Intervention on Participants' Families

The objective of the sub-study on participants' families was to evaluate the nature of the support that family members give to their relative who is homeless, and how participation in HF may influence this. Semi-directed interviews were conducted with 14 family members near study entry, distributed among the HF and TAU groups. Two years later, eight family members were re-interviewed. The results suggest that receipt of HF tends to lead to a reduction in housing and financial help, while emotional and social support tend to be maintained. Family members expressed relief that their relative was being helped by professionals, as well as that they seemed to be finding the motivation to improve their situation.

²² In particular, a qualitative study of community organizations participants made positive comments about during the baseline interviews is still in progress.

Comparison of Community-Based and Institutional ICM Teams

MN participants assigned to HF were randomized at the outset, not only to community-based housing or scattered site apartments, but also to either the CSSS Jeanne-Mance ICM team, or the Diogène ICM team. The former was operating within the institutional health care sector, while the latter was managed by a community-based not-for-profit organization. A comparison of outcomes for participants of the two teams indicates that there was no statistically significant difference on any of the outcomes we measured. In addition, we carried out qualitative interviews on sub-samples of 10 participants per team, to explore possible differences in the nature and effectiveness of the intervention, given the difference in case managers of the two teams. Preliminary conclusions from these analyses suggest that differences among individual case managers are much more significant from the point of view of participants than any overall differences across the teams. These results indicate that HF-ICM can be implemented successfully in Québec either by an institutional provider or by a not-for-profit community organization.

Effects of Peer Support Workers in HF Services

Another sub-study examined the effects of including peer support workers on the clinical teams. It relied on interviews and focus groups conducted with three peer support workers, 15 workers from the clinical teams, two team leaders, two psychiatrists, and two administrators.

Peer support workers were reported to have helped to make the teams' clinical practices more recovery-oriented. Their experience helped team members to better appreciate participants' problems. Interviewees identified several practices that were either developed or improved

by the integration of peer workers among their ranks, notably: adoption of a less stigmatizing vocabulary; reduced emphasis on clinical diagnosis, as merely representing a "diagnostic perspective;" reliance on the participants' expression of their own needs; trust in peer support workers' advice, such as when they proposed a delay in seeking a court order to force participants to take medication; earlier intervention when participants' symptoms seem to have gone "too far;" mention of alternative mental health resources in institutional settings that team members may not have known

about; informing clinicians of symptoms experienced by participants in crisis; and promotion of practices designed to help participants assume responsibility for themselves.

This sub-study provided a rich description of the benefits of integrating peer support workers into HF teams. Peer support workers clearly contributed to practices becoming more tailored to the needs of participants, a fundamental aspect of the HF model.

CHAPTER 8

CONCLUSIONS AND IMPLICATIONS

The Montréal Chez Soi project has yielded three overarching conclusions.

- 1 It is feasible to implement the Pathways to Housing variant of Housing First (HF) in Montréal.** Two hundred and seventy-six individuals experiencing homelessness with mental health problems were housed in apartments of their choice, almost all on the private rental market, within three months of being recruited. A sufficient number of landlords were found who were willing to collaborate with the project, thanks to the support that the housing and clinical teams could offer. It also proved possible to recruit, train, and establish housing and clinical teams. At the same time, the Montréal experience confirmed what research has already proven, namely that establishing such teams requires the sustained presence and involvement of outside consultants and trainers. High-level organizational commitment is also needed, so that clinical teams can be given the flexibility to work in a way that the HF model requires.
- 2 The intervention proved effective.** Many more participants were housed stably, and in apartments corresponding more closely to their preferences, than was the case for participants receiving services as usual. While the quantitative scales did not show differences between the groups that were as large as expected, the qualitative interviews suggest that perhaps this was mostly due to the relatively short time horizon of the study. It is clear that, for most participants, the combination of: (1) being quickly housed in a decent, independent apartment that they had helped choose and that they could afford (with support for rehousing when needed), AND (2) being supported by a skilled team of professionals who were seeking to help them achieve their own goals and dreams in a non-judgemental way and giving them as much control as possible over the way their services were delivered and over the direction of their lives, set them on a new and much more positive life trajectory.
- 3 The intervention was also cost-effective.** The net cost of the intervention, once avoided costs of shelters, hospitalizations, and other resources are taken into account, is quite small in relation to the significant benefits realized. Furthermore, the duration of follow-up was only two years. Some of our results suggest that the cost offsets would increase over time. The qualitative interviews in particular suggest that participants receiving HF services were, for the most part, on improving trajectories. As their lives become more ordered, many may need less intensive clinical supports. Some may become able to enter or re-enter the labour force and, as a result, not only no longer need welfare or disability benefits, but also contribute to the economy through their work. Their physical and mental health may stabilize. Longer-term follow-up of the participants would provide valuable information on trends in costs as well as other outcomes.

The intervention proved effective. Many more participants were housed stably, and in apartments corresponding more closely to their preferences, than was the case for participants receiving services as usual.

What does the Chez Soi study imply for the direction that should be given to homelessness services and policy in Montréal? We see three main implications:

1 Access to HF services similar to those developed by Pathways to Housing in New York City and in the Chez Soi project should be increased. If such programs were sufficiently scaled up, the number of people experiencing homelessness and living with a mental illness in Montréal could be significantly diminished. This general implication in turn has at least two specific implications:

- a) The number of available rent supplements needs to be increased, as most participants prefer being housed in independent private-market apartments, and can live in such settings successfully. Currently in Montréal, there are many calls for increased access to social housing as a means of combating homelessness. Although the label “social housing” already covers a great variety of options, an implication of this study is that it would be feasible, desirable from the point of view of people who are homeless, effective, and economically justifiable, to instead call more broadly for “affordable housing,” also including rent supplements to be used in conjunction with mobile support teams, as in the Chez Soi project.
- b) Training and consulting services must be developed to promote high-fidelity implementation of HF programs. As noted in the national report, and as suggested by Montréal's own findings, higher fidelity to the HF model is associated with better outcomes in terms of both housing stability and quality of life.

Our results confirm what is now widely thought in other jurisdictions: Housing First programs must be considered as one of several essential components in a systemic approach to ending homelessness (Canadian Alliance to End Homelessness).

2 Additional research needs to be carried out to better understand how the effectiveness of HF services can be increased, for those people for whom it was not effective.

3 Participants expressed appreciation for certain features of Chez Soi services – immediate access to housing, long-term follow-up by ACT or ICM teams, a non-judgemental attitude, and being empowered to make their own decisions – that they could also, in many cases, recognize and appreciate in existing services. These features are consistent with a recovery orientation, which is being promoted throughout the mental health system. The broadest implication of the Chez Soi project is thus an invitation for all services to resolutely adopt a recovery orientation, if they have not already done so.

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APPENDIX 1

KEY DEFINITIONS

Eligibility

Inclusion Criteria:

- Legal adult status (aged 18 or older/19 in British Columbia)
- Housing status as absolutely homeless or precariously housed*
- The presence of a serious mental disorder[^] with or without a co-existing substance use disorder, determined by DSM-IV¹ criteria on the Mini International Neuropsychiatric Interview (MINI)² at the time of study entry

Exclusion Criteria:

- Currently a client of another ACT or ICM program
- No legal status as a Canadian citizen, landed immigrant, refugee or refugee claimant
- Those who are relatively homeless*

Need Level

High need must have:

A score on the Multnomah Community Ability Scale (MCAS) of 62 or lower (functioning indicator) AND a Mini International Neuropsychiatric Interview (MINI) diagnosis of current psychotic disorder or bipolar disorder (MINI disorders 18, 21 or 22 on the Eligibility Screening Questionnaire) or an observation of psychotic disorder on the screener (at least two of Q 6e10 in Section DI) on the Eligibility Screening Questionnaire (diagnostic indicator) AND one of:

- YES (or don't know or declined) to item 20 on Demographics, Service & Housing History questionnaire; that is, two or more hospitalizations for mental illness in any one year of the last five (service use indicator) OR Comorbid substance use (any of MINI disorders 23, 24, 25 or 26 on the Eligibility Screening Questionnaire) (substance use indicator) OR recent arrest or incarceration.
- YES (or don't know or declined) to item 22 on Demographics, Service & Housing History questionnaire (legal involvement indicator).

Moderate need

- All others who have met eligibility criteria but do not meet the criteria above.

Absolutely Homeless / Precariously Housed*

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).ⁱⁱⁱ 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^{iv} 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.

iii The UN definition of homelessness originally included individuals in transition using transition homes and hostels. The present project modified the definition to exclude this subgroup.

iv Definition adopted from Tolomiczenko, G. and Goering, P.3

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).

Stable Housing

Stable housing was defined as living in one's own room, apartment, or house, or with family, with an expected duration of residence greater than or equal to six months and/or tenancy rights.

REFERENCES FOR APPENDIX 1

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APPENDIX 2

Principal measurement instruments and interview schedule

MEASURE	BASELINE	EVERY 3 MONTHS	EVERY 6 MONTHS	21/24 MONTHS
Demographics	★			
Housing, vocational, service use history	★			
Physical comorbidities	★			
Residential, vocational time-line follow-back		★	★	★
Mental health and substance abuse (Colorado Symptom Index, GAIN, VMAP 2)	★		★	★
Health status/Generic quality of life (SF-12, EQ-5D)	★		★	★
General quality of life (Lehman QoLI-20)	★		★	★
Condition-specific quality of life (Lehman QOLI-20)	★		★	★
Recovery (RAS)	★		★	★
Community functioning (Multnomah Community Ability Scale - MCAS)	★		★	★
Working alliance (WAI provider and participant versions)			★	★
Working alliance (Provider and participant versions)			★	★
Cognitive impairment	★			★

APPENDIX 3

METHODS

Methods used for the economic analysis

The economic analyses were conducted from the point of view of society. Service use and residential questionnaires enabled us to assess quantities of a wide range of services used, as well as of income from various sources. We estimated unit costs (e.g., the average cost of an emergency room visit, of a police arrest, of a night in a shelter) city-by-city using the best available data. For the Montréal analysis, approximately 140 distinct unit costs were estimated. In many cases, service providers were contacted to obtain their financial and activity reports and to help interpret them. When a program's expenditures included contributions by private donors, as well as government sources, we included the value of private contributions as this represents the full cost of service delivery from the point of view of society. Welfare and disability payments were included as they represent costs that society must incur in order to enable individuals experiencing homelessness to participate in and benefit from Housing First programs and other existing housing programs.²³ Income from employment was subtracted from overall costs as this represents the value of a contribution to society by the individual. Estimates of capital costs were included in all services. All costs were expressed in FY 2010 - 2011 Canadian dollars. Due to the two-year follow-up period, we did not apply discounting.

²³ Weisbrod BA, Test MA, Stein LI: Alternative to Mental Hospital Treatment: II. Economic Benefit-Cost Analysis. Archives of General Psychiatry 37:400-5, 1980

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