



WINNIPEG FINAL REPORT

At Home/Chez Soi Project



Mental Health
Commission
of Canada

Commission de
la santé mentale
du Canada

AT HOME/CHEZ SOI PROJECT: WINNIPEG SITE FINAL REPORT

The authors wish to acknowledge the contributions of the many individuals whose efforts and expertise made this report possible.

Many individuals have contributed to this project over the past four years. To the co-investigators, for their input into the planning, design, and evaluation; to the research/interview teams who dedicated their time and energy to the participants with whom they interacted on a regular basis; to the Winnipeg site leadership team, including site and housing procurement leads; to the Winnipeg service team providers for working with us and teaching us as we made our way through; and, most importantly, to all the Winnipeg participants who gave of themselves, sharing their lives, stories and insights, and without whom this project would not have been possible.

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MAIN MESSAGES

FROM THE WINNIPEG AT HOME/CHEZ SOI PROJECT

1

Successful, culturally safe partnerships were developed and maintained among universities, local Aboriginal organizations, and government. Multiple key stakeholders were engaged in the development and ongoing operations of the Winnipeg site project from its inception. Its three community-based Housing First (HF) intervention teams included an Assertive Community Treatment (ACT) team for participants with high needs (HN) and two moderate need (MN) Intensive Case Management (ICM) teams – one serving Aboriginal participants (ICM AB) and a second, open ICM team with a range of participants (ICM-open) that included Aboriginal and non-Aboriginal persons.

2

Winnipeg study participants represent a distinct group. The participants for the service use and costing results reported here includes all of the ICM, ACT, and Treatment as Usual (TAU) groups in Winnipeg (N=513). Sixty-four per cent were male and 36 per cent were female. Seventy-one per cent reported they were of Aboriginal descent. There are many indications that participants had multiple challenges in their lives that contributed to their disadvantaged status. For example, 69 per cent did not complete high school. Most study participants were recruited from shelters or the streets, with 69 per cent being absolutely homeless and 31 per cent in precarious living situations. At entry, participants reported symptoms consistent with the presence of various mental illnesses, including concurrent disorders, such as substance-related problems (77 per cent) and post-traumatic stress disorder (PTSD) (45 per cent). Additionally, more than 99 per cent of participants reported at least one physical health condition and 83 per cent reported a traumatic brain injury. On average, our participants were exposed to six different categories of child abuse and/or neglect before the age of 18. Nearly half (49 per cent) reported a history in foster care, 42 per cent had parents who attended residential school, and 11 per cent had attended residential school themselves.

3

Housing First was successfully implemented in Winnipeg in a manner faithful to the model, yet tailored to the local Aboriginal context. Involvement and engagement of the Aboriginal community and organizations occurred at all levels of the project's implementation, delivery, and decision making. With knowledge of the legacy of colonialism and respect for Indigenous cultural practices, all service teams integrated an Aboriginal holistic approach in delivering Housing First to participants and elders, and traditional teachers were integrated as part of the services and programming offered to participants. At the same time, excellent research follow-up rates were achieved (81 per cent) and outcomes clearly favour the Housing First approach in Winnipeg. In the last six months of the study, 45 per cent of HF participants were housed all of the time, 28 per cent some of the time, and 27 per cent none of the time; whereas 29 per cent of TAU participants were housed all of the time, 18 per cent some of the time, and 52 per cent none of the time. This finding is particularly noteworthy given the extremely low vacancy rate for rental housing in Winnipeg. Also, housing quality in a random sample of 84 participants was, on average, as good for HF residences as for TAU residences for those who got housing over the course of the study.

EXECUTIVE SUMMARY

FROM THE WINNIPEG AT HOME/CHEZ SOI PROJECT

The Winnipeg At Home/Chez Soi project is an example of a successful, culturally safe partnership among universities, local Aboriginal organizations, and government, engaged together in the development and ongoing operations of the Winnipeg site project from its inception.

According to the 2011 Census, Winnipeg is a community of 730,018 people, and is home to Canada's largest urban Aboriginal population, accounting for more than 10 per cent of the city's population.

Since 1991, there has been an overall decline in the vacancy rates for rental property in Winnipeg, which during the course of the study remained in the range of one per cent or lower. Such low vacancy rates in both public and private housing markets have contributed to long waiting lists for those seeking affordable shelter. As a result, landlords have been able to be more selective in reviewing tenant applications. Further, approximately 40 per cent of the rental housing stock is located within Winnipeg's inner city where housing is older and increasingly in need of major repair. This has placed considerable pressure on the rental market with fewer options for those seeking rental accommodations.

Correspondingly, a recent report published by a central local shelter indicated that of the 300 surveyed individuals who were homeless, approximately 70 per cent were male and, overall, respondents were five times more likely to report being of Aboriginal descent than the general Winnipeg population.

Program Descriptions

The three Housing First (HF) intervention teams in Winnipeg included one Assertive Community Treatment team (ACT) through Mount Carmel Clinic for participants with high need level (HN), and two moderate need (MN) Intensive Case Management-based teams through Ma Mawi Wi Chi Itata Centre (ICM-open) and the Aboriginal Health and Wellness Centre of Winnipeg (AHWC), which served only Aboriginal participants (ICM AB). The Winnipeg Regional Health Authority (WRHA) coordinated housing procurement in association with Housing Plus (an organization developed by the Winnipeg site to build capacity, procure furniture, set up apartments, coordinate move-ins and move-outs, and manage the repairs and supports to landlords). The WRHA also worked with service teams to identify appropriate housing, and educated landlords in terms of Aboriginal Cultural Awareness and Mental Health First Aid. Participants who were not randomized to a HF intervention (that is, all Treatment as Usual [TAU] participants) continued to receive any services or supports available through existing community and clinical services.

Sample Characteristics

More than half of our study sample was middle aged, with 37 per cent under the age of 34 and 6 per cent over the age of 55. While males are more numerous in the homeless population, we strove for a higher sample of women to learn more about this under-studied group. Males made up 64 per cent and females 36 per cent of our sample. The majority of our participants (71 per cent) reported that they were Aboriginal, and five per cent reported other ethnocultural status. Only five per cent of our sample was married or living common-law, but 47 per cent reported having one or more children. However, very few children were living with participants at the time of study enrollment. A small but important percentage (five per cent) of participants are veterans, having reported wartime service for Canada or another country. There are many indications that participants have multiple challenges in their lives that have contributed to their disadvantaged status. For example, 69 per cent did not complete high school, and 47 per cent reported that their prior month income was less than \$300. While 91 per cent were unemployed at the time of study entry, 52 per cent had worked steadily in the past, which suggests a reasonable potential for re-employment after stabilization in housing.

Homelessness History

Most study participants were recruited from shelters or the streets, with 69 per cent absolutely homeless and 31 per cent in precarious living situations (refer to Appendix 1 for definitions). One in five first became homeless in the year prior to entering the study. The longest single past period of homelessness is reported by participants to be approximately 30 months, and the typical total time homeless in participants' lifetimes is nearly five years.

Past and Current Personal, Health, and Social Circumstances

At entry, Winnipeg participants reported symptoms consistent with the presence of various mental illnesses, including concurrent disorders such as substance-related problems (77 per cent) and PTSD (45 per cent, compared to 29 per cent across all five study sites). Twenty-two per cent of participants have had two or more hospital admissions for a mental illness in any one-year period in the five years before study enrollment. Additionally, over 99 per cent of participants reported at least one physical health condition, 82 per cent reported a traumatic brain injury, and nearly 45 per cent indicated they have a learning problem or disability. Further, on average, our participants were exposed to six different categories of child abuse and/or neglect before the age of 18. Almost half (49 per cent) reported a history in foster care, while 42 per cent had parents who attended residential school and 11 percent had attended residential schools themselves. Participants lacked basic social support, with around half reporting having no one to confide in. General distress levels were also high, with 40 per cent reporting symptoms consistent with moderate to high suicide risk. (Note: There were standard referral processes followed in the study if a participant was deemed at risk of suicide.)

Program Implementation and Housing Outcomes

Housing First was successfully implemented in Winnipeg in a manner faithful to the model, yet tailored to the local Aboriginal context, including a keen awareness of the legacy of colonialism for this population. Excellent research follow-up rates (completion of final interview) were achieved – 81 per cent overall (HF – 87 per cent and TAU – 75 per cent) – and outcomes clearly favour the Housing First approach in Winnipeg. In the last six months of the study, 45 per cent of HF participants were housed all of the time, 28 per cent some of the time, and 27 per cent none of the time; whereas 29 per cent of TAU participants were housed all of the time, 18 per cent some of the time, and 52 per cent none of the time. Again, with historically low vacancy rates, securing housing remained an ongoing challenge. Additionally, housing quality (including housing unit, building, and neighbourhood) was measured using standard ratings by our field research team in a random sample of 84 Winnipeg participants. Housing First residences (unit and building) had similar average quality and less variable quality compared to residences for the smaller group of TAU participants who found housing. Further, for a representative sub-group from whom we collected more detailed life stories, being housed generally enabled participants to come out of survival mode; establish a stable, normal routine; focus on their health; and orient to the future. In turn, this allowed some to engage in productive, meaningful activities such as volunteering, going back to school, or gaining employment, while others were still working through refocusing their lives.

Cost Outcomes

The sample for the service use and costing results reported here included all of the ICM-open/ICM AB, ACT, and Treatment as Usual (TAU) groups in Winnipeg (N=513). We evaluated the economic impact of the Housing First programs, considering all costs incurred by society. The HF intervention cost \$18,840 per person per year on average for HN participants, and \$12,552 per person per year for MN participants. These costs include salaries of all front-line staff and their supervisors, additional program expenses such as travel, rent, utilities, etc., and rent supplements provided by the Mental Health Commission of Canada (MHCC) grant. The HF intervention for HN participants is more costly mainly because of the higher staff: participant ratio. Over the two years after participants entered the study, by comparing the costs of services incurred by participants who received HF services with those of participants who received usual services, we found that receipt of HF services resulted in average reductions of \$17,527 in the cost of services for HN participants, and \$4,838 for MN participants. Thus, every \$10 invested in HF services resulted in an average savings of \$9.30 for HN participants, and \$3.85 for MN participants. This net savings arises from a combination of decreases in the costs of

some services (cost offsets), and increases in the costs of others. For HN participants, the main cost offsets were hospitalizations in the medical units of general hospitals (\$7,056 per person per year), hospitalization in psychiatric settings (\$4,181 per person per year), office visits in community health centres and other community providers (\$3,752 per person per year), incarceration in jail or prison (\$2,282 per person per year), outpatient consultations (\$1,417 per person per year), living in transitional housing settings (\$1,203 per person per year) and drug or addiction treatment or residential recovery programs (\$1,067 per person per year). At the same time, one cost in particular increased: visits at day centres (\$1,816 per person per year). For MN participants, the main cost offsets were hospitalizations in medical units in general hospitals (\$3,321 per person per year), living in transitional housing settings (\$1,720 per person per year), office visits in community health centres and other community providers (\$1,296 per person per year), and drug or addiction treatment or residential recovery programs (\$1,184 per person per year). At the same time, one cost in particular increased: hospitalizations in psychiatric settings (\$3,161 per person per year). Other cost offsets and increases were all less than \$1,000 per person per year.

Social and Health Outcomes

Overall, observer-rated assessments of community functioning showed significant improvements in all HF intervention groups compared to TAU groups. Further, a representative sub-group of participants who shared life stories indicated that having both decent housing and a trusting relationship with an At Home/Chez Soi (or other) worker enabled them to gain control over their social relationships, reconnect with previous positive relationships such as children and family, and begin to establish new ones. Participant-reported quality of life improved significantly at final follow-up in the ICM-open group vs. TAU, while substantial improvement in overall community functioning and social skills over the entire study period was observed amongst people in the ICM AB group compared to those in the ICM-open and TAU groups. There was no difference in these outcomes between the ACT group compared to the HN TAU group.

CHAPTER 1

INTRODUCTION

Over a four-year period (2009-2013), the Winnipeg At Home/Chez Soi site successfully implemented and demonstrated the effectiveness of a culturally appropriate Housing First research demonstration project that randomized 513 individuals to receive either Housing First (HF) or Treatment as Usual (TAU – existing clinical and community services). The City of Winnipeg was initially selected as a site for the At Home/Chez Soi project due to the over representation of Aboriginal people in this city who were homeless and living with mental illness. The Winnipeg model was based on creating and maintaining culturally safe partnerships among local Aboriginal¹ and non-Aboriginal organizations, universities, and government departments. The Winnipeg site's foundational principle was to work collaboratively to build and strengthen capacity in our community. At the time of the project's inception, HF had not been attempted in Winnipeg. As such, preliminary work focused on bringing partners together, building trust, and creating an environment capable of sustaining HF over the long term. Equally important was ensuring local Indigenous communities not only supported efforts to implement HF, but also played a leading role in all aspects of the project. The image below (Figure 1) illustrates the range of key partners involved in the delivery of Housing First in Winnipeg.

The Winnipeg model was based on creating and maintaining culturally safe partnerships among local Aboriginal and non-Aboriginal organizations, universities, and government departments.

Figure 1: Winnipeg At Home/Chez Soi Partners



¹ The term "Aboriginal identity" refers to whether the person reported being an Aboriginal person; that is, First Nations (North American Indian), Métis, or Inuk (Inuit), and/or being a Registered or Treaty Indian (that is, registered under the Indian Act of Canada), and/or being a member of a First Nation or Indian band. Aboriginal peoples of Canada are defined in the Constitution Act, 1982, section 35 (2) as including the Indian, Inuit, and Métis peoples of Canada.

The Winnipeg approach proved that HF, with cultural adaptations, presents an effective means by which to reduce and end homelessness within the Aboriginal and non-Aboriginal population.

Three community-based intervention teams delivered HF in Winnipeg:

- **Wiisocotatiwin** - Mount Carmel Clinic supported participants with high needs (HN) using an Assertive Community Treatment (ACT) model;
- **NiApin** - the Aboriginal Health and Wellness Centre of Winnipeg provided a “made in Winnipeg” model of service, and supported moderate need (MN) Aboriginal participants using their existing “Medicine Wheel” model with elements of the Intensive Case Management (ICM AB) model incorporated; and
- **Wichewin** - Ma Mawi Wi Chi Itata Centre supported moderate need (MN) Aboriginal and non-Aboriginal persons using an Intensive Case Management (ICM-open) model.

In Winnipeg, it was critical to locally adapt HF to ensure that Indigenous values were infused throughout the service and program delivery model for both staff and participants. This included ensuring Aboriginal input at the leadership level (e.g., Site Coordinator), taking a more holistic approach, being relationship-based, having a communal focus, being strengths-based, and including traditional Indigenous ceremonies and protocols. We were able to successfully and effectively augment the standard HF model (as developed in the United States) with these cultural adaptations.

The Winnipeg approach proved that HF, with cultural adaptations, presents an effective means by which to reduce and end homelessness within the Aboriginal and non-Aboriginal population.

To achieve the successes observed in Winnipeg, teams worked to ensure staff members with lived experience of homelessness and mental health issues and those with Aboriginal heritage were involved. Project staff received appropriate cultural proficiency training according to their level of need. For example, on-going staff training and staff ceremonies were held, including sharing circles, sweats, and learning from elders. In addition, staff were trained in Métis history, trauma-informed care, and vicarious trauma. This training was often done using more of a ceremony format versus common lecture method. In addition, two of the three service teams were developed from existing local Aboriginal organizations (Ma Mawi Wi Chi Itata Centre and the Aboriginal Health and Wellness Centre), which had in-house cultural training and supports. This was fundamental in being able to work with Aboriginal people who are homeless by using a broader social and historical lens that was integrated into the recovery work. To support this approach, the HF model was culturally adapted. Assessments and case plans were developed using a holistic framework that included the “Medicine Wheel,” the Seven Teachings, and having elders and traditional Aboriginal teachers accessible to both staff and participants (Appendix 2a). This was a fundamental part of recovery and healing and gave participants

the ability to take part in ceremonies, sharing circles, and one-on-one consultations.

Perhaps the most challenging work undertaken by the teams in Winnipeg was addressing issues of racism, discrimination, poverty, residential school impact, and institutional involvement with child welfare and justice that has contributed to generational layers of trauma. Dealing with these types of systemic traumas, especially among Indigenous participants, was complex and challenging but critical for supporting recovery and healing. Each service team worked to incorporate trauma-informed practice in their delivery approaches.

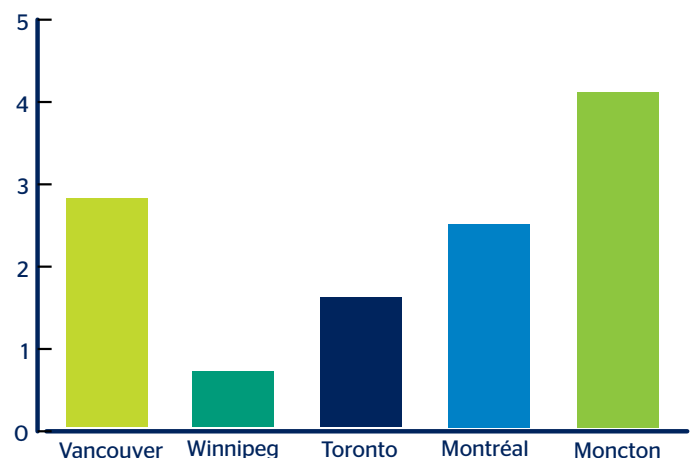
Overall, Winnipeg’s efforts were successful and HF proved to be more effective when compared to the current service system. This brief report outlines some of the key findings from the Winnipeg site. Our intent is to provide a broad overview of the work and accomplishments achieved over a nearly five-year period.

Our work, efforts, and the results are owed centrally to the participants in the study who made this project possible. Every member of the Winnipeg site shared in the successes and challenges that were observed and realized. As well, for those persons randomized to the treatment as usual group, we thank and honour their meaningful contribution. All persons involved in the Winnipeg site shared many stories and our purpose is to honour their words, thoughts, and ideas as best we can.

Background and City/Provincial Context

Winnipeg is a mid-sized prairie city of 730,018 people, with a median age of 39.2. Winnipeg is home to Canada’s largest urban Aboriginal population with 72,335 persons self-identifying during the 2011 Census. The Aboriginal population comprises 9.9 per cent of the city’s total population. This growing urban Aboriginal population is also much younger. In Winnipeg, Aboriginal children

Spring 2011 Vacancy Rates for all At Home/Chez Soi Sites



aged 14 and under represented 28.8 per cent of the total Aboriginal population and 18.6 per cent of all children in Winnipeg. Non-Aboriginal children aged 14 and under accounted for 15.7 per cent of the non-Aboriginal population (NHS Statistics Canada, 2011). Correspondingly, a report published by a local shelter indicated that of the 300 adults surveyed who were homeless, approximately 70 per cent were male and, overall, respondents were five times more likely to report being of Aboriginal descent than the general Winnipeg population (The Winnipeg Street Health Report, 2011). Street population estimates of persons who are homeless in Winnipeg consider upwards of 80 per cent to be from Aboriginal communities. Table 1.0 presents an estimate of Winnipeg's homeless population at a time point near the beginning of the At Home/Chez Soi Project as compared to two other cities in Manitoba.

Since 2001, the vacancy rate has remained well below two per cent, including a low of 0.8 per cent in 2010. Low vacancy rates in Winnipeg's private housing market have also contributed to long waiting lists for those seeking affordable shelter within the public and not-for-profit sectors. Winnipeg's housing vacancy rate remained below national averages and that of the other At Home site cities during the course of the study. There was a slight moderation in 2013 when the rate climbed to 1.9 per cent (See Figure 2). It is important to note that a balanced rental market, in which there is

Table 1.0 Estimated Homeless and at Risk Populations, March 31, 2007 (Institute of Urban Studies, 2007)

SUB-GROUP	WINNIPEG	BRANDON	THOMPSON	TOTAL
At risk of homelessness	135,000	3,800	2,275	141,075
Hidden homelessness	7,600	1,478	70	9,148
Living on the street	350	33	982	1,365
Short-term or crisis sheltered	1,915	164	375	2,454
Supportive housed	n/a	74	148	222

adequate choice, is often noted as having a vacancy rate of between three and four per cent.

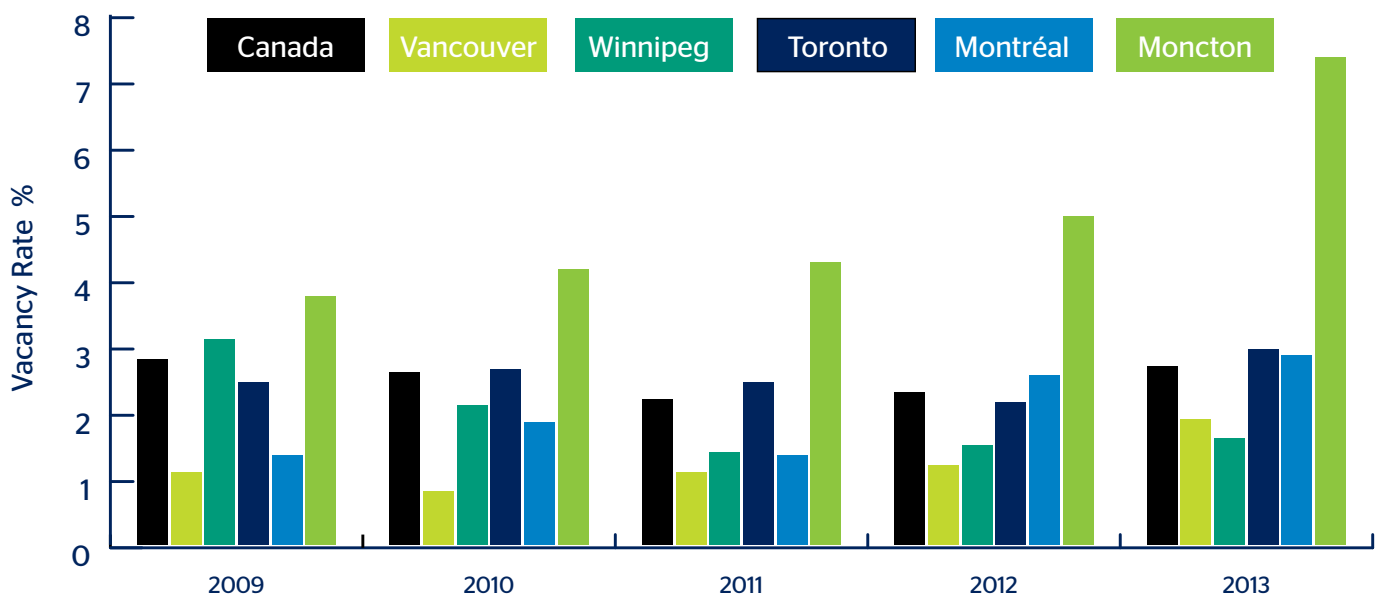
Approximately 40 per cent of rental housing supply is located within Winnipeg's inner city, where housing is generally older and increasingly in need of major repair.² This has placed considerable pressure on the rental market with fewer quality and central options existing for those looking for affordable rental options. Core Housing Need, Canada's measure of shelter inadequacy, is assessed by Canada Mortgage and Housing Corporation (CMHC) using three indicators: affordability, adequacy, and suitability. In Winnipeg, Core Housing Need impacts 9.5 per cent of all households, meaning that these dwellings may be in need of repair, the household pays more than 30 per cent for shelter, or the household is considered to be crowded (CMHC, 2012).

The Winnipeg Regional Health Authority (WRHA) provides general services for individuals with mental health issues, including Supportive Housing (with on-site

support staff and case management). The WRHA also operates mental health residential care facilities through its Community (Supported) Living and Community Mental Health programs. In addition, the WRHA offers a Program of Assertive Community Treatment (PACT).

As noted, Winnipeg did not have a Housing First team that combined services with housing at the outset of the project in 2009. The WRHA was seen as a key partner in the Winnipeg At Home project, given its strong history of working with vulnerable populations and providing housing. The housing delivery aspect of the WRHA was critical, as it had established relationships with the housing sector. This proved to be invaluable to allowing the Winnipeg team to secure housing in the early stages of the project.

Figure 2: At Home/Chez Soi City Rental Unit Vacancy Rates (Source: CMHC, Rental Market Reports: 2010-2013)



² The inner city is a geographic boundary in Winnipeg's central city and is denoted by a concentration of neighbourhoods designated as being disproportionately concentrated with poverty, poor quality housing and increasing numbers of marginalized groups. While much effort has occurred to address issues in the inner city, it remains an area of policy concern.

CHAPTER 2

DESCRIPTION OF THE WINNIPEG SITE

Programs and Delivery Model

As noted, successful, culturally safe partnerships were developed and maintained among local Aboriginal and non-Aboriginal organizations, universities, and government departments. The three teams in Winnipeg managed service delivery, including assisting with housing procurement. The Ma Mawi Wi Chi Itata Centre undertook provision of the Intensive Case Management (ICM) intervention known as Wi Che Win, while the Mount Carmel Clinic (MCC) Wiisocotatiwin team was responsible for implementing the Assertive Community Treatment (ACT) intervention. The Aboriginal Health and Wellness Centre of Winnipeg offered the NiApin Program (ICM AB) as the site-specific (“Third Arm”) intervention. This program is a “Medicine Wheel”/ICM model with an additional day program and provides housing alternatives to its constituents at first point of entry into the program. As noted previously, the Winnipeg Regional Health Authority (WRHA) coordinated housing procurement in association with Housing Plus and Manitoba Green Retrofit (MGR), and worked with the Service Teams to identify appropriate housing. They also played an educational role with landlords in terms of Aboriginal Cultural Awareness and Mental Health First Aid.

Research

The research component of the project was a joint venture consisting of oversight by principal investigators at the University of Winnipeg, Institute of Urban Studies, with expertise in urban housing, and the University of Manitoba, Department of Psychiatry, with expertise in mental health. Both groups have had extensive experience in working with Aboriginal populations in their respective areas of expertise. Members of the interview teams from both universities, including members with lived experience, collected data for the project. Details of data collection methods are found in Appendix 1.

Leadership

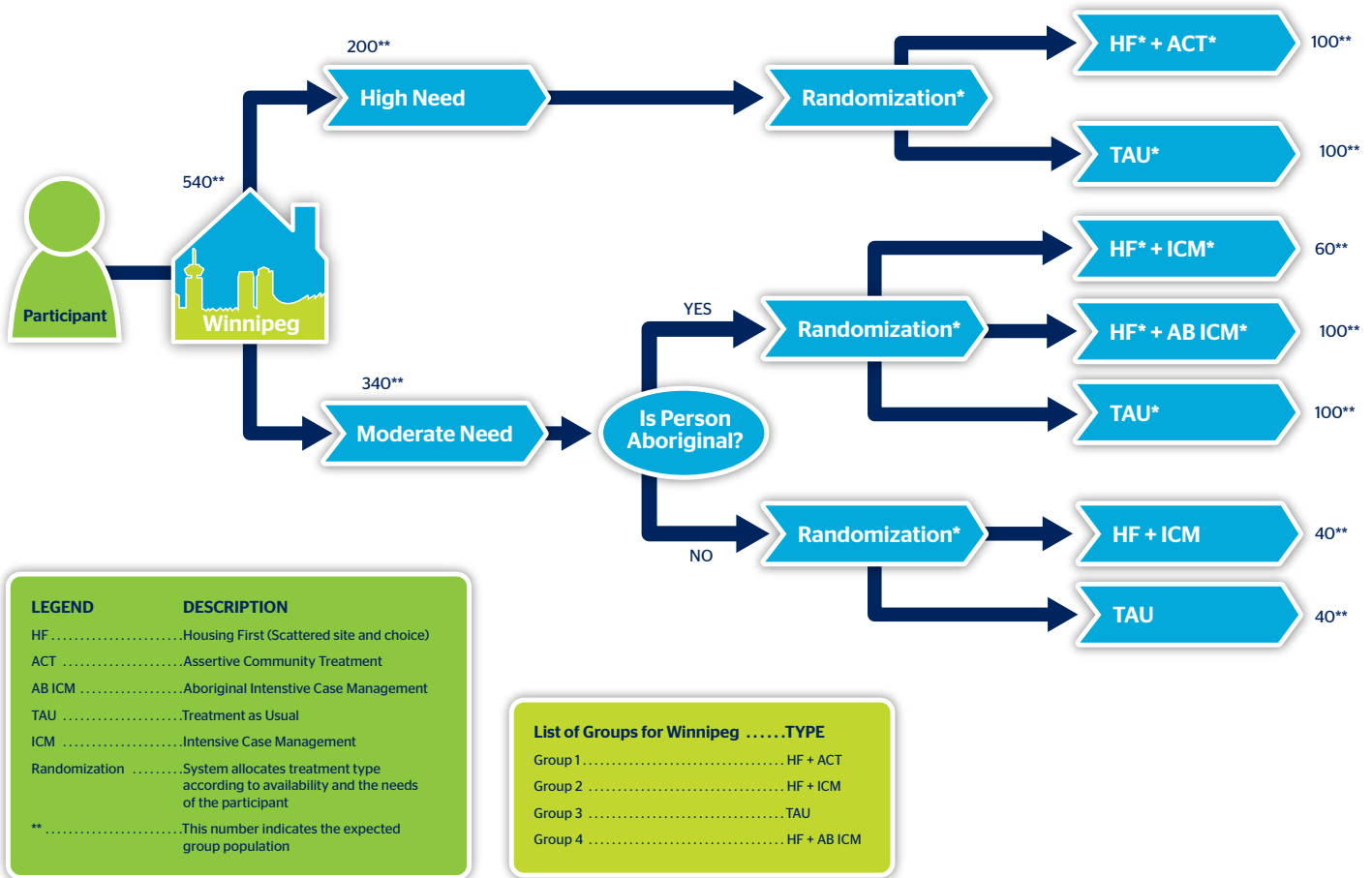
The Project Leadership Team (comprised of the Site Coordinators, Project Consultant, Co-Principal Investigators, Research Coordinator, Lead Service Providers, and the Housing Procurement Team) provided overall management and coordination of the Winnipeg project. To support the local site, an Advisory Committee was established to help secure holistic and effective partnerships across housing, service, and health care sectors. In addition, the Winnipeg site supported the Lived Experience Circle (LEC). The LEC ensured that Aboriginal perspectives were honoured and promoted. Throughout the Winnipeg site, people with lived experience (PWLE) of mental health and of homelessness were represented in various roles: on the Advisory Committee, as staff with the service providers, and as research team members. The inclusion of Aboriginal perspectives and of PWLE in mental health and homelessness were considered integral to the Winnipeg site (see Appendix 2b for a chart illustrating the structure of the Winnipeg site).

CHAPTER 3

CHARACTERISTICS OF THE WINNIPEG SAMPLE

In total, 513 participants were recruited and enrolled at the Winnipeg site, including the Intensive Case Management (ICM), Assertive Community Treatment (ACT), and Treatment as Usual (TAU) groups. See Figure 3 for flow diagram of study.

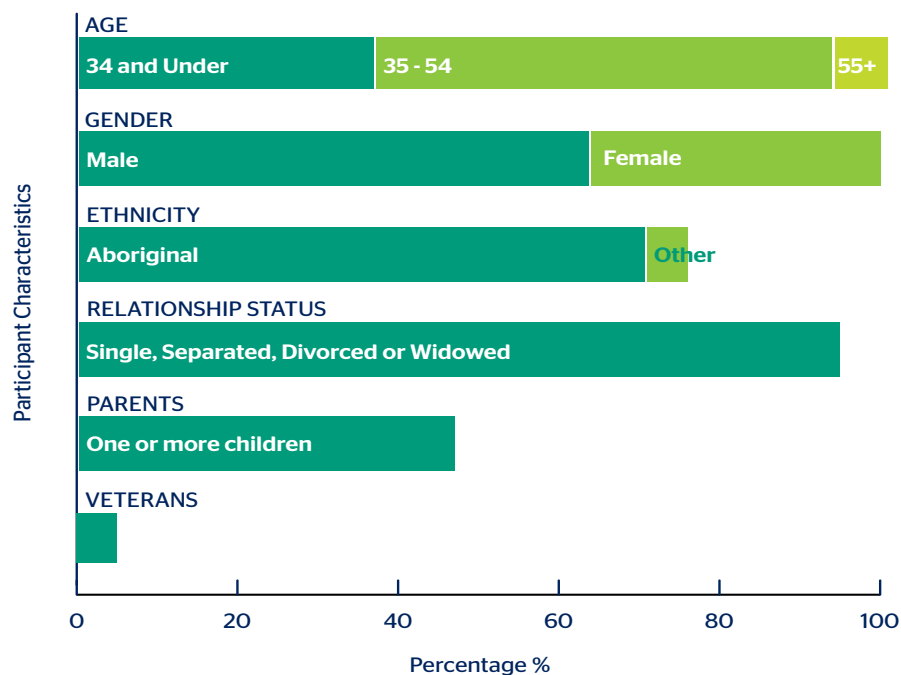
Figure 3: Flow Diagram of Study.



More than half of the Winnipeg site sample was middle aged, with 37 per cent under the age of 34 and six per cent over the age of 55. While males are more visibly numerous in the homeless population, we strove for a higher sample of women to learn more about this under-studied group. Males made up 64 per cent and females 36 per cent of our sample. The majority of our participants (71 per cent) reported that they were of Aboriginal descent, and five per cent reported other ethnocultural status. Only five per cent of our sample was married or living common-law, but 47 per cent reported having one or more children. However, very few children were living with participants at the time of study entry (see Table 2 for demographic details.) Veterans are an important but small percentage (five per cent) of the sample (this group reported wartime service for Canada or another country). There are many indications that participants have had multiple challenges in their lives that have contributed to their circumstances. For example, 69 per cent did not complete high school, and 47 per cent reported their prior monthly income was less than \$300. As well, 91 per cent were unemployed at the time of study entry. It is important to note that 52 per cent have worked steadily in the past, which suggests a reasonable potential for re-employment after stabilization in housing (see Table 2).

Recruitment

Recruitment in Winnipeg occurred over an 18-month period beginning in fall of 2009 and extending to June of 2011, with data collection completed in June 2013. The research team spent considerable time working with Winnipeg's social service agencies, health clinics, and local hospitals, providing information about the project and the parameters of the study to support the referral process. As well, it was the intent of the research team to ensure that participants were drawn from a range of locations and providers. While the majority of participants were recruited from shelters, the Winnipeg site team did manage to connect with close to 50 different groups and agencies that referred clients to the study (see Appendix 3 for map of locations of Winnipeg Referral Agencies).



History of Homelessness Among Participants

When examining the history of homelessness among study participants, we found that 69 per cent were absolutely homeless, with 31 per cent living in precarious living situations, such as single room occupancy hotels or rooming houses (refer to Appendix 1a for definitions). Geographically, the majority of the sample was drawn from inner city locations with a clustering in Winnipeg's Main Street area.

One in five of our participants first became homeless in the year prior to entering the study. The longest single past period of homelessness is reported by participants to be on average 33 months, with the typical total time homeless in participants' lifetimes being nearly five years; however, some participants had experienced lifetime homelessness for more than 400 months (see Table 3). Most became homeless in their late 20s or early 30s.

Table 2: Winnipeg Site Demographic Characteristics of Participants at Study Entry

	TOTAL SAMPLE N =513 %	HN ANALYSIS N =199 %	MN ANALYSIS N =314 %
AGE GROUPS			
34 or younger	37	41	35
35-54	57	57	57
55 or older	6	2	8
GENDER			
Male	64	59	67
Female	36	41	33
Other	<1	0	<1
COUNTRY OF BIRTH			
Canada	97	95	98
Other	3	5	2
ETHNIC STATUS			
Aboriginal	71	68	72
Other ethnocultural	5	5	5
MARITAL STATUS			
Single, never married	70	72	69
Married or common-law	5	5	5
Other	25	23	26
PARENT STATUS			
Any children	47	47	47
EDUCATION			
Less than high school	69	74	67
High school	12	12	12
Any post-secondary	19	14	21
PRIOR MILITARY SERVICE (for Canada or an ally)	5	5	5
PRIOR MONTH INCOME less than \$300	47	45	49
PRIOR EMPLOYMENT (worked continuously at least one year in the past)	52	44	57
CURRENTLY UNEMPLOYED	91	93	89

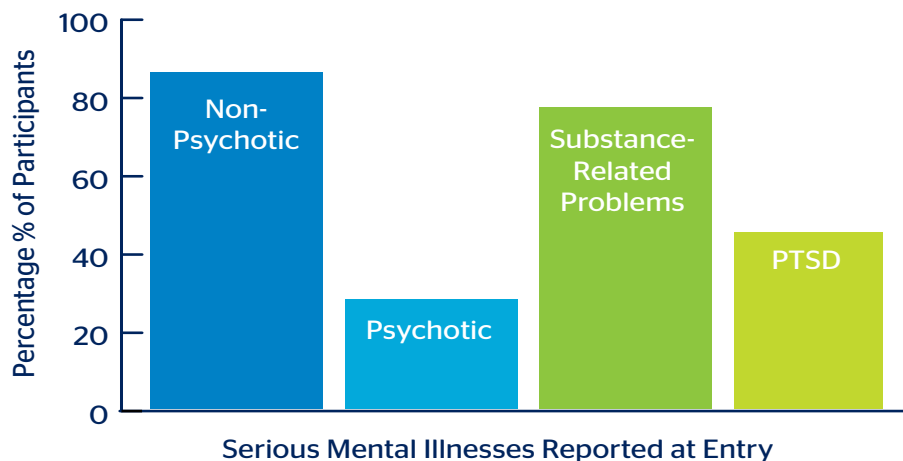
Table 3: Homelessness History - Winnipeg

	TOTAL SAMPLE N =513 %	HN ANALYSIS N =199 %	MN ANALYSIS N =314 %
HOMELESS STATUS AT ENROLMENT			
Absolutely homeless**	69	71	68
Precariously housed	31	28	32
FIRST TIME HOMELESS			
The year prior to the study	22	16	26
2008 or earlier	78	84	74
LONGEST PERIOD OF HOMELESSNESS IN MONTHS (lowest and highest rounded to next month)	33 (1-324)	38 (1-324)	31 (1-324)
TOTAL TIME HOMELESS IN LIFETIME IN MONTHS (lowest and highest rounded to next month)	60 (1-420)	61 (1-420)	59 (1-324)
AGE FIRST HOMELESS (lowest and highest rounded to next month)	29 (1-68)	27 (1-65)	31 (7-68)

* All information was reported by participants except where noted.

** See Appendix 1a for definitions of absolutely homeless and precariously housed.

On average, our participants were exposed to six different categories of child abuse and/or neglect before the age of 18.



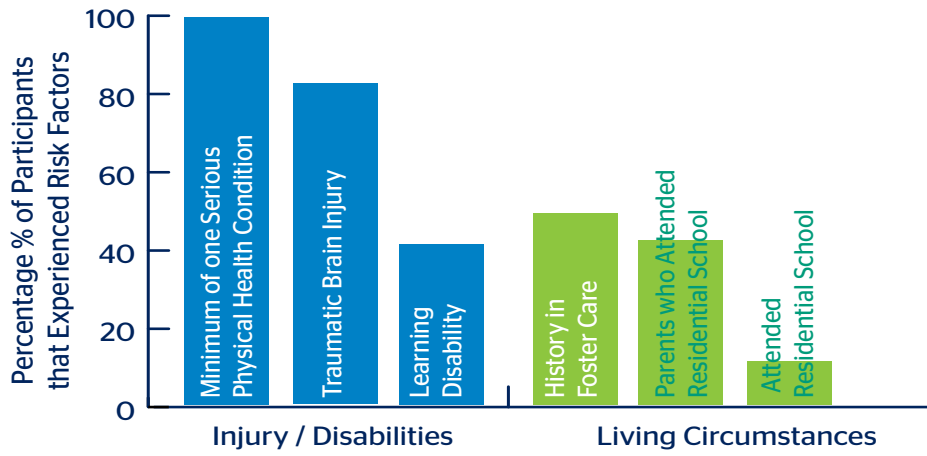
Past and Current Personal, Health, and Social Circumstances

At entry, participants reported symptoms consistent with the presence of the following mental illnesses: 28 per cent psychotic disorder; 86 per cent non-psychotic disorder; concurrent disorders such as substance-related problems (77 per cent) and post-traumatic stress disorder (PTSD) (45 per cent, compared to 29 per cent across all five study sites). Twenty-two per cent of participants had two or more hospital admissions for a mental illness in any one-year period in the five years before study entry. Additionally, over 99 per cent of participants reported at least one serious physical health condition and 82 per cent reported a traumatic brain injury. Nearly 41 per cent reported having a learning problem or disability. Further, on average, our participants were exposed to six different categories of child abuse and/or neglect before the age of 18. Almost half (49 per cent) reported a history in foster care while 42 per cent had parents who attended residential school and 11 per cent had attended residential school themselves.

Thirty-five per cent of participants reported having been involved with the criminal justice system in the six months prior to the study and many had experienced victimization within the same time period. Forty-one per cent reported being robbed or threatened to be robbed, 55 per cent reported being threatened with physical assault, and 51 per cent reported being physically assaulted (see Appendix 4).

Participants also lacked basic social supports, with approximately half reporting having no one in which to confide. General distress levels were also high with 40 per cent reporting symptoms consistent with moderate to high suicide risk (see again Appendix 4). (Note that there were standard referral processes that were followed in the study if a participant was deemed at risk of suicide.)

It is important to note the unique history and characteristics of the Winnipeg participants in comparison to participants across all study sites (Vancouver, Winnipeg, Toronto, Montréal, and Moncton). For instance, the Winnipeg group had more female participants (36 per cent vs. 32



per cent), many more Aboriginal participants (71 per cent vs. 22 per cent), 28 per cent of Winnipeg participants had three or more children versus nine per cent of the overall sample, and 77 per cent of Winnipeg participants had substance-related problems vs. 67 per cent of the total study participants. Further, 49 per cent of Winnipeg participants had lived in foster care, 47 per cent had 10 or more exposures to traumatic events, approximately 42 per cent had a parent or grandparent who had attended Residential School, and 11 per cent had attended residential school themselves. These distinctive characteristics have important implications for both risk of homelessness as well as the process of recovery for the Winnipeg participants, particularly given the legacy of colonialism experienced by the Aboriginal population (Royal Commission on Aboriginal Peoples [RCAP], 1996).

CHAPTER 4

HOUSING OUTCOMES

Housing First (HF) was successfully implemented in Winnipeg in a manner faithful to the model and included culturally appropriate adaptations that focused on the local Aboriginal context. Excellent research follow-up rates were achieved (81 per cent overall) and outcomes clearly favour the HF approach in Winnipeg. This finding is particularly noteworthy given the extremely low vacancy rate and overall affordability levels in the city (see Figure 1).

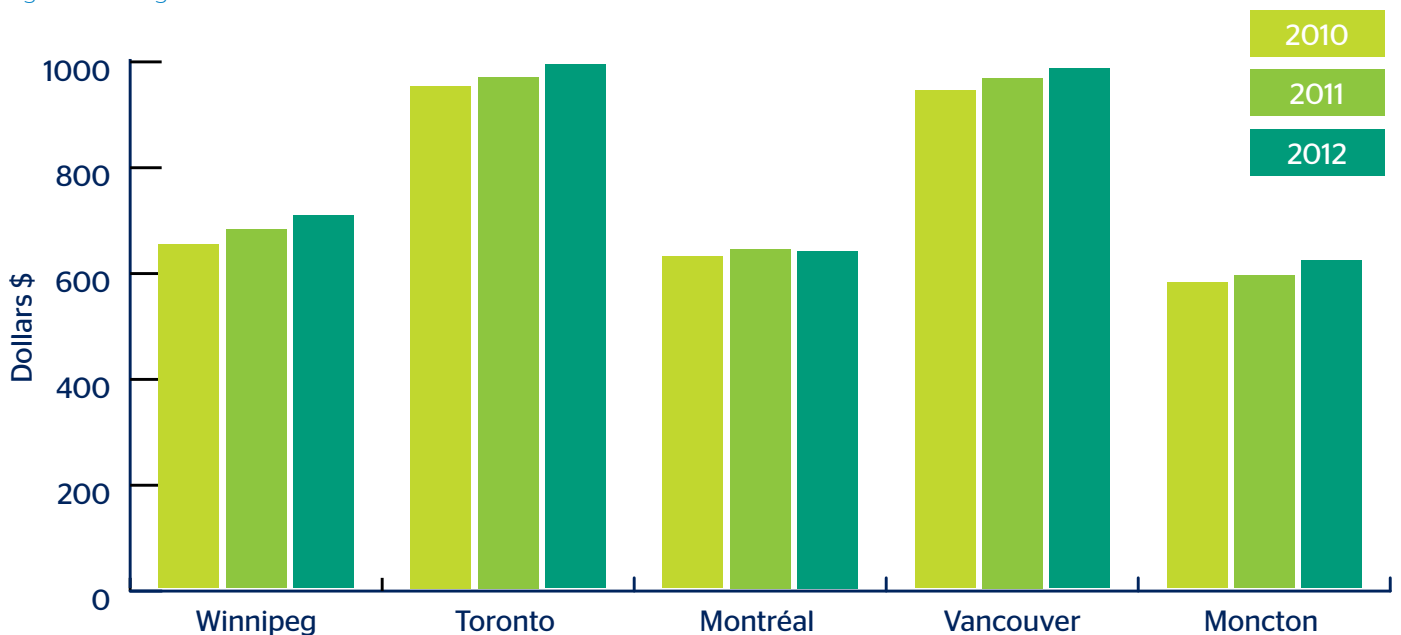
Getting participants housed proved to be an extremely challenging aspect of the Winnipeg project. At the outset, the Winnipeg Regional Health Authority (WRHA) worked to establish an inventory of housing options for participants. This included securing a range of units in various locations, coordination of the rent supplements, and working with landlords.

An additional capacity-building initiative in Winnipeg included the development of Housing Plus³ and Manitoba Green Retrofit (MGR).⁴

In the early phases of the project, numerous obstacles to securing affordable and quality housing arose. Many of these early challenges were the result of difficult market conditions, with most options tending to be centrally located and of variable quality. The limitations to housing choice were related to higher rents that tended to exist outside of the inner city. Thus, a key effort was made to use rent supplements to offer participants greater choice. The thought was that this would open up housing in other neighbourhoods that would have otherwise been unaffordable for those relying solely on the \$285 shelter assistance rates provided by the Province of Manitoba.⁵

Utilizing rent supplements allowed the service teams to access private market housing that was closer to the average rent of just over \$600 per month at the start of the project in 2009. However, rents also climbed to more than \$700 by the end of the project, which created a more difficult situation as the project entered the final stages (see Figure 4). It is important to note that rent supplements in Winnipeg averaged \$200, meaning that housing staff could secure apartments for around \$500 per month (\$285 Shelter Assistance plus \$200 MHCC supplement). It should also be noted that in some cases, higher supplements were used to access additional units of housing when the supply of available housing was impacted by fierce competition, especially when vacancy rates dipped below one per cent. These conditions also

Figure 4: Average One Bedroom Rent Amounts

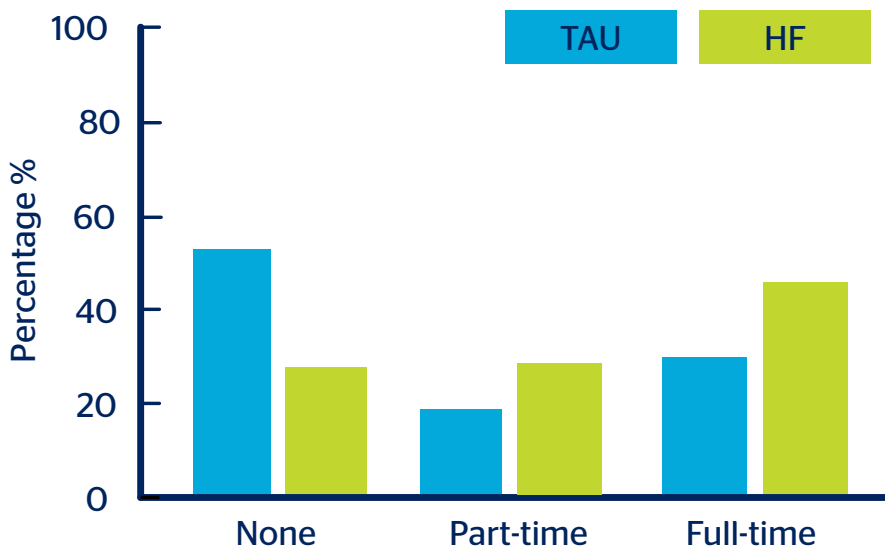


³ Housing Plus was developed by the Winnipeg site to procure furniture, set up apartments, coordinate move-ins and move-outs, and manage the repairs and supports to landlords. Housing Plus was intended to be the focal point for the creation of capacity building along these lines. In addition, Housing Plus formed strong relationships with other social enterprises who supported key components of the housing delivery model.

⁴ Manitoba Green Retrofit (MGR) was developed by the Winnipeg site to assist with apartment repairs and maintenance, including bed bug remediation.

⁵ Shelter assistance rates are determined by the Manitoba Employment and Income Assistance Program (EIA). Rates can be accessed at <http://www.gov.mb.ca/ctt/eia/>

Figure 5: Time in Housing - Final Six Months of Study (Winnipeg Overall HF vs TAU)



delayed participants in finding housing as housing staff were spending significant time looking for units. During the course of the study, many local strategies emerged to speed up the process of finding apartments, including convening weekly meetings to share information and work across the three teams to allocate housing as efficiently as possible.

Despite difficult market conditions, the Winnipeg site was able to provide a range of housing choices for HF participants, and in a broader selection of neighbourhoods and locations. At March 31, 2013, the distribution of locations offered a good selection of places for participants to live (see map, Appendix 5).

Providing a range of location choices and higher-quality units was important and thought to contribute to overall housing stability. To explore this in more detail, National Research Team members, including one Winnipeg lead investigator, developed and tested an Observer-rated Housing Quality Scale (OHQS). The intent was to systematically and objectively document the level of housing quality between HF and Treatment as Usual (TAU) groups, and across sites, since other research has shown consistent relationships between housing quality and mental health. The OHQS focused on overall housing quality (including housing unit, building, and neighbourhood) and was measured using standard ratings by our field research team.

Two trained members of the research team rated housing quality independently in a random sample of 84 Winnipeg participants. Despite Winnipeg's market, residences provided to HF participants by the study were of similar average quality, and were less variable (more consistent) in quality than the housing TAU participants were able to secure on their own or through other housing programs and services (for those housed for at least two months over the study period). This is an important finding as providing quality, safe, and affordable housing is considered fundamental to housing stability, and it also confirmed that public funds for rent supplements were not going to substandard or unhealthy properties.

Time Spent in Housing

Despite Winnipeg's challenging housing market, positive housing outcomes were observed. In the last six months of the study, 45 per cent of HF participants were housed all of the time, 28 per cent some of the time, and 27 per cent none of the time. In comparison, 29 per cent of TAU participants were housed all of the time, 18 per cent some of the time, and 52 per cent none of the time (see Figure 5 and Table 4). From Figure 5, it is important to highlight the large difference between the HF and TAU groups with respect to per cent of participants housed "none of the time."

While the majority of HF participants had been housed at least some if not all of the time, some were back in shelters due to a range of factors such as incidents resulting in eviction, intermittent incarceration, and/or disconnection with their At Home service team. For some participants, this was frustrating, yet others seemed content where they were and were hopeful that they would be rehoused in the near future. On the other hand, between 26 and 46 per cent of TAU participants were also housed during the entire study period with the support of a community mental health/ social agency worker, partner, or relative. *"And, well, through [staff person], she used to work at [a] Mission, she like exhausted a lot of hours trying to find us a place. Finally we got this place, it's not the greatest but it's been home, it's just an apartment, one bedroom".* (HN TAU)

Many participants initially struggled with being able to maintain stable housing. This was because they had to deal with

Table 4: Comparison of Housing Stability Across all Winnipeg Groups

SERVICE TEAM	No time in stable housing Per cent	Some time in stable housing (>0, <100) Per cent	Entire period in stable housing Per cent
WiCheWin			
MN, AB, HF + ICM (n=53)	30	36	34
MN, non-AB, HF + ICM (n=40)	20	18	63
NiApin			
MN, AB, HF + AB ICM (n=72)	26	24	50
Wiisocaotatiwin (ACT)			
HN, HF + ACT (n=82)	28	28	40
All TAU			
HN TAU (n=73)	55	19	26
MN, AB TAU (n=66)	55	21	24
MN, non-AB, TAU (n=35)	43	11	46

"Well, when you work for something you feel a lot better ... but then I started to feel this is my place. First couple of months, I didn't feel like, this is not mine, but now I feel, I hope."

challenges such as learning to live indoors, interacting with neighbours and friends, adhering to their responsibilities as tenants, managing ongoing substance use issues, and disentangling from unhealthy relationships. During narrative interviews with a representative subsample of 45 participants, some HF participants expressed scepticism and hesitancy about the housing received through the At Home project when they first moved into their apartment. One young man did not believe it was real, and worried about when it would be taken away from him. *"Well it was like, when I first moved in, I says, 'is this mine? This is not mine, I don't belong here, I didn't earn this...'* Well, when you work for something you feel a lot better ... but then I started to feel this is my place. First couple of months I didn't feel like, this is not mine, but now I feel, I hope."

However, other HF participants said they learned – through trial and error and recurring evictions or “move-outs” – which types of housing, which neighbourhoods, and the degree of personal boundaries that worked best for them to be able to remain stably housed. One young HF woman noted that she had attempted so many times to maintain stable housing in a HF supplied apartment but without success. As such, she found housing in a rooming house, which appeared to be a better fit for her at that point in her journey as she had maintained this housing for three months, her longest stretch yet. Others realized after a time that allowing certain individuals into their apartments ultimately resulted in undesirable outcomes such as evictions due to partying, excessive noise, or unit damage. For a few HF participants, even

though they continued to experience multiple moves within a one-year period, the reason for the moves had changed. Rather than moving to escape abuse from partners or others, they reported frequent moves because of restrictions and rules of the places regarding their alcohol use or bringing in visitors.

CHAPTER 5

SERVICE USE OUTCOMES

For some participants, thinking about making the decision to seek professional services for mental health support only happened once they were more stably housed and had supportive relationships.

Service Use Outcomes (By Program) and Costs

Gains in understanding and management of mental health issues were evident at the follow-up narrative interviews with a representative subsample of participants within the Housing First (HF) groups and in a few Treatment as Usual (TAU) participants who had managed to connect with a mental health worker. Many HF participants indicated they were now under the care of a psychiatrist or psychologist, which provided opportunities to engage in discussions related to their illness, medications, or therapy.

Some HF participants also spoke of accessing support for both physical and mental health needs from general practitioners or psychiatrists connected with their At Home/Chez Soi service team or their local parent organizations.

I see Doctor [general practitioner] in the building here, that's my doctor. Anything that comes up or ... I go see her, like, sometimes when monthly check ups or forget refills on the medication or she sends me for, like, a blood test or something or anything that comes up.

Well I, I get medication from Doctor [psychiatrist], uh from ACT. He gives me pills for my anxiety and my depression.

In contrast, many TAU and a few HF participants were still struggling with mental health issues at follow-up interviews and had not seen any changes, nor sought or received additional treatment in this area.

For some participants, thinking about making the decision to seek professional services for mental health support only happened once they were more stably housed and had supportive relationships — either personal or with an At Home/Chez Soi team worker. At a follow-up interview, a HF participant indicated that he “Haven't gone to see a, I don't know if it's a therapist, a shrink or psychiatrist, think that's all the same profession, but I was, I, I would like to talk to someone, a professional, get their professional diagnosis, if there is anything.”

It may be anticipated that once individuals have housing and a team of supports, they would no longer use emergency services. However, a HF participant's response to questions around service use outside of his At Home/Chez Soi Assertive Community Treatment (ACT) team indicates that individuals may continue to use

these services, at least in the short term, because of the support and relationships they had previously established while being on the street. The following interview excerpt illustrates this well:

Interviewer: How about any clinical supports or hospital-based treatment outside of the ACT team, have you...

Participant: Well, I go to the emergency when I need medication or something like that, I go to Health Science Centre emergency. I use them as a, for getting pills and that eh, like they give me T3s for my thumb.

Interviewer: Any idea how often that, like in the last year, year and a half, how often you might of gone to emerg at HSC?

Participant: Quite a bit of times, yeah, the social worker there knows me, put it that way. Every time I go there now she's there. She comes to talk with me and see how things are going, she helps out a lot when I'm there, and she helps get me through the system at the hospital, eh.

Interviewer: So you, you talked about that you went there, I guess I'm just wondering, you know, what are some of the reasons why you're going there [Health Sciences Centre Emergency]? You talked about getting T3s for your thumb...

Participant: Well, the pills or just, if I got nowhere to go, just to be off the streets, I'll sit in the, the waiting room there and watch TV. All night just to be off the street where it's cold.

Interviewer: Okay, and have you been doing that, like even since you've been with the ACT?

Participant: Yeah, yeah I've been doing that even though I was on the ACT team.

...every \$10 invested in HF services resulted in an average savings of \$9.30 for high need participants, and \$3.85 for moderate need participants.

Cost Outcomes

The sample for the service use and costing results reported here includes all of the ICM-open/ICM AB, ACT, and TAU groups in Winnipeg (N=513). We evaluated the economic impact of the Housing First programs, considering all costs to society. The HF intervention cost \$18,840 per person per year on average for high need participants, and \$12,552 per person per year for moderate need 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 high need participants is more costly mainly because of the higher staff:participant ratio. Over the two-year period after participants entered the study, by comparing the costs of services incurred by participants who received HF services with those of participants who received usual services, we found that receipt of HF services resulted in average reductions of \$17,527 in the cost of services for high need participants, and \$4,838 for moderate need participants. Therefore, every \$10 invested in HF services resulted in an average savings of \$9.30 for high need participants, and \$3.85 for moderate need participants. This net savings arises from a combination of decreases in the costs of some services (cost offsets), and increases in the costs of others. For high need participants, the main cost offsets were hospitalizations in medical units in general hospitals (\$7,056 per person per year), hospitalization in psychiatric settings (\$4,181 per person per year), office visits in community health centres and other community providers (\$3,752 per person per year), incarceration in jail or prison (\$2,282 per person per year), outpatient consultations \$1,417 per person per year, living in transitional housing settings (\$1,203 per person per year), and drugs or addiction treatment or residential recovery program (\$1,067 per person per year). At the same time, one cost in particular increased: visits at day centres (\$1,816 per person per year). For moderate need participants, the main cost offsets were hospitalizations in medical units in general hospitals (\$3,321 per person per year), living in transitional housing setting (\$1,720 per person per year), office visits in community health centres and other community providers (\$1,296 per person per year), and drugs or addiction treatment or residential recovery programs (\$1,184 per person per year). At the same time, one cost in particular increased: hospitalizations in a psychiatric setting (\$3,161 per person per year). Other cost offsets and increases were

all less than \$1,000 per person per year. It is important to note that while there are additional costs incurred with implementing HF, in addition to the public services being used, many HF participants were stably housed over the course of the study, whereas those in the TAU group were using similar public services but with many still experiencing homelessness. It is also important to note that the discussions on changes in service use as reported here are based on self-report. Because recall can be challenging and not always accurate, more information based on analysis of health and justice administrative data is underway and will be reported in 2014.

During narrative interviews with a representative subsample of participants, those who had become stabilized over the 18 months spoke of now having a steady income through Employment and Income Assistance (EIA) – a connection facilitated via their At Home worker. Some HF participants had developed new budgeting skills and were learning how to manage their finances more efficiently. They also noted that the regular income had assisted in improving their eating and personal hygiene patterns, as food and supplies could now be purchased. Others conveyed with a sense of pride that their incomes had actually decreased since being housed with the At Home project, because they were no longer engaging in illegal activities, such as prostitution or dealing drugs.

Changes in financial stability or financial situations for a representative subsample of TAU participants appeared to depend on their level of support and insight into their spending patterns. For example, one TAU participant had realized that it would be better to receive income assistance on a weekly basis while another expressed frustration at a continuous feeling of vulnerability.

"It's changed a little bit. I used to get [it] all, every two weeks, now I'm getting money every week, it's being arranged that way. 'Cause I was spending my money foolishly, pigging out on food, you know go to movies a lot, you know ... But I arranged it so I would have money in my pocket ... And I asked my ment-, uh I mean uh my EIA worker, I want a bus pass voucher instead. It's the same as money, but that'll help me a lot."

"No, it's just the same, I guess, I don't know, people ask me for things I give them and I don't know. I always gives – gave and gave and give and nobody gives me back."

...those who had become stabilized over the 18 months spoke of now having a steady income through Employment and Income Assistance (EIA) – a connection facilitated via their At Home worker. Some HF participants had developed new budgeting skills and were learning how to manage their finances more efficiently.

CHAPTER 6

SOCIAL AND HEALTH OUTCOMES

Community Functioning and Quality of Life

Numerous assessments of health and social outcomes – both self-reported and observer-rated – were collected over the study period. Participants were asked to report on their quality of life, while trained members of the research team made objective observations as to participants' community functioning. Overall, community functioning showed significant improvements over the study period in all Housing First (HF) intervention groups compared to Treatment as Usual (TAU) groups. Also, substantial improvement in overall community functioning as well as increased social functioning over the entire study period was observed amongst Aboriginal participants in the Intensive Case Management (ICM) AB group compared to Aboriginal participants in both the ICM-open and TAU groups. There were no differences found between the high need HF (ACT) group and the high need TAU group in community functioning, neither over the study period nor at the final follow-up interview. In addition, participant-reported quality of life improved significantly at final follow-up in the non-Aboriginal HF ICM participants compared to the non-Aboriginal TAU participants. There was no difference in these outcomes between the ACT group compared to the high need TAU group.

Further, a representative subgroup of participants who shared life stories indicated that having both decent housing and a trusting relationship with an At Home/Chez Soi (or other) worker enabled them to gain control over their social relationships, reconnect with those with whom they had previous positive relationships such as children and family, and begin to establish new ones.

At 18 months into the study, participants involved in qualitative interviews, particularly HF, shared that they had experienced some fairly significant changes in their daily lives. These can be characterized as "coming out of survival mode" and feeling more safe and relaxed; establishing a normal, daily routine that was less dominated by addictions or illness; for some, becoming more future-oriented; and, gaining control over daily social interactions.

Coming out of Survival Mode

When participants were first enrolled in the study, they were struggling through the day to meet basic survival needs, such as staying warm, obtaining enough food to eat, or ensuring their physical safety. As one participant said: *"it's an up and down kind of thing, it's some days, it's just the meal won't be there, some days it's ... yeah, just water ... You know just try to make the next day."* Eighteen months into the project, participants who had obtained housing talked about coming out of the mode of daily survival. They talked about how not being preoccupied with survival and constantly *"moving from place to place"* meant their days were becoming *"more safe and relaxed."* One HF person, for instance, talked about how good it felt to be able to come home, *"instead of walking back and forth, or under the bridge at 40 below ... and eating from the garbage cans."* As another HF participant described the change: *"Well, when you're on the streets, you're more or less just in survival now mode...[Right now]...I'm not worrying about [any] other stuff other than I wonder what I'm gonna watch this afternoon."*

Establishing a More Normal Daily Routine

At the first narrative interview, many participants talked about how their days were dominated by addictions (i.e., preoccupied with getting drugs, or the money needed to secure them). Others talked about how their daily routines were hindered by mental health problems, such as struggling with moods or symptoms of mental illness. For instance, an ACT participant related the experience of dealing with his psychological problems, of *"not being able to sit still, like all this moving, and the panic attacks..."* At eighteen months, housed participants' lives had become less preoccupied with addictions or mental health concerns. As the same participant said: *"I feel a lot less anxiety ... where outside I had anxiety all the time."* Another HF participant, who still struggled with a significant drinking problem, talked about how he was *"drinking coffee more often,"* rather than alcohol. Being less preoccupied with survival or addiction meant they could establish *"a nice routine"* that was more normal. As an ICM AB participant put it:

"If I have something to do early, I get up. Most of the time I just watch a couple of my favourite programs on TV in the morning ... and start shaking loose about noon ... I sometimes I come downtown ... and eat breakfast in one of the restaurants ... I'm getting to be a regular there, too ... I'm getting back into the scheme of things here, a regular grind you know ... I'm slowly going back to being a regular Joe."

Social and Cultural Connections/Reconnections

Relationships and Connections

During qualitative interviews conducted just after study entry with a representative subsample, one of the major crosscutting themes that emerged conveyed significant disconnection from family and friends (i.e., losing touch) and alienation from family (i.e., burning bridges), and the loss of meaningful connections. Many participants did, however, express a desire to disentangle, reconnect, and establish new types of relationships in addition to wanting to be part of a “normal” life.

At the 18-month follow-up qualitative interviews, a reoccurring theme of the importance of positive connections resurfaced, helping participants in the Housing First groups, as well as some in the TAU groups, to “get back on their feet” and gain a sense of belonging. These relationships were with a variety of individuals including At Home service team workers, partners (boyfriends/girlfriends), community agencies, mental health workers, and so on. Overall, the follow-up narratives from HF participants relayed more positive changes than those of the TAU participants.

Gaining Control over Social Interactions

At the interviews conducted just after study entry, participants’ daily lives were often caught up with the troubles of others on the street, or of those whom they lived with in close quarters in a shelter or rooming house environment. At 18 months, this had changed, particularly for those who had found decent housing (including both TAU and HF), which had given them more control over their social interactions, since, “*You don’t have any people banging on your door or shouting down the hallways or anything.*” Another issue people reported struggling within initial interviews was that there were few opportunities for social interaction that didn’t involve drug or alcohol use. As one participant put it, “*You more or less have to drink in order to be with people who have a place to congregate to somewhere you know, especially in the winters.*” At 18 months, HF participants talked about “*not having to worry about someone coming over with a bottle in their hands*” and being tempted to use. Overall, their comments indicated that by becoming housed, they had gained a significant degree of control and choice over their social interactions. However, some HF participants still struggled with social isolation and with “*bringing the wrong people*” into their apartments. After setbacks (e.g., losing an apartment due to partying), some had begun to learn how to set boundaries in order to stay clear of addictions and keep their place. As one HF participant said, “*...not all the time I have the right people ... that I talk to ... so in the past six months I could say I’m talking to more positive people.*”

Repairing or Reconnecting with Culture and Family

As a result of their personal progress, many HF participants began re-establishing or strengthening relationships with family members. For example, relationships with parents seemed to have stabilized or improved for some, while others spoke of their desire to get back in touch with their family members, reconcile with them, and become more involved in their lives. Several HF participants shared accounts of significant changes in their relationships with their children and parents. One man had gained custody of his young son who was now living with him. Another man shared a powerful story of his reconciliation with his mother:

“I went to her [participant’s mother] one day and broke down and told her that I’m sorry for all the hurt and pain I caused her, and anybody else, that I never meant to do the things I’d done ... And then I hugged her and kissed her, just held her ‘cause I never had done that before.” (ICM AB participant)

Others, however, including some in HF, were still alienated from their families or had lost touch with them over the past year. “*I haven’t seen my family in a while. Sometimes I just forget about them [laughs].*”

A meaningful change discussed by numerous HF participants in the narrative interviews, particularly those in the ICM Aboriginal group, was the reconnection with previously estranged family members or children “in care.” Having housing allowed participants to focus on other areas of their lives such as their mental health, addictions, or healing. Through the support of their At Home team workers, HF participants became more stable and began to make significant changes in their lives. For instance, a key goal of the HF intervention in Winnipeg was family reunification. This was achieved by a number of participants from each of the HF groups. Through the support of At Home service teams, participants’ relationships with their parents and children were mended, numerous participants were spending more time visiting with their children who were in care, newborns were going home with their mothers, and several participants who are parents were able to regain custody of their child(ren) who had been in care (Child and Family Services [CFS]) due to having stable housing and the positive changes they had made in their lives. These milestones are particularly relevant as nearly half of the Winnipeg participants were parents at the time of enrolment in the study, but were not caring for their children at the time. Reconnecting and regaining custody of their children from CFS also has significant implications for cost savings from this system.

Further, as part of their healing process since coming into the At Home project, participants in the ICM and ICM Aboriginal groups also spoke of changes regarding connections or new learning with their Aboriginal culture, often through resources such as elders, available through their At Home service team. While all Winnipeg teams provided opportunities for engagement in culturally-relevant activities and mentorship, participants in the ICM groups seemed to speak about this aspect the most.

Having housing allowed participants to focus on other areas of their lives such as their mental health, addictions, or healing. Through the support of their At Home team workers, HF participants became more stable and began to make significant changes in their lives. For instance, a key goal of the HF intervention in Winnipeg was family reunification.

Mental Health, Addictions, and Recovery

Differences between the groups were not found on all of the health status measures in the study (including some mental health and substance use variables). For some measures, this was because both groups improved similarly. We believe this may be due to most participants having been in crisis at study entry, followed by expected patterns of stabilization. These findings are reported in greater detail in the scientific articles, which will be published shortly. The in-depth qualitative narratives did show progress with recovery, mental health, and addictions for numerous participants, particularly for those in the Housing First groups. The nature of the qualitative interviews (vs. quantitative surveys) may have allowed for more nuanced description of changes experienced by participants over the study period. For example, reduced drug and alcohol and substance use was commonly mentioned during the qualitative interviews. One ICM AB female participant noted the following about how she spent time had changed over the course of the project:

HF Participant: *"I don't sniff any more. I don't hang around with uh, uh, street people, I don't hang around with the people I used to hang around with before that, that made me unhealthy cause I was getting myself really unhealthy."*

Interviewer: That's good. And why do you think those things have changed?

HF Participant: *"Because I got a place and I don't wanna lose it."* [laughs]

Numerous HF participants indicated they were also now connected with mental health professionals and were receiving appropriate support with medications and illness management. Numerous Aboriginal participants spoke of gaining insight into historical trauma, and into family relationships, which had facilitated their recovery journey.

Gains in understanding and management of mental health issues were particularly evident at the follow-up interviews within the HF groups and in a few TAU participants who had managed to connect with a mental health worker. Participants in all HF groups spoke of a clearer understanding of their mental illness, improved illness/medication management, and decreased symptoms. Many HF participants were now under the care of a psychiatrist or psychologist, which provided opportunities to engage in discussions related to their illness, medications, or therapy. Participants in the ACT and ICM Aboriginal groups in particular, spoke of how connections and positive relationships with their At Home workers also assisted in their capacity to develop helpful coping mechanisms when dealing with anger, frustrations, past traumatic experiences, and relationships with others. In contrast, many TAU and a few HF participants were still struggling with mental health issues and had not seen any changes in this area.

Gaining Insight into Anger, Emotions, and Historical Trauma

A number of Aboriginal HF participants who were part of the "Sixties Scoop" (Alston-O'Connor, 2010; Sinclair, 2007) or who had attended a Residential School (RCAP, 1996) – both a legacy of colonialism – had long been living with pent-up anger and confusion. With the assistance of their At Home team and/or the Truth and Reconciliation process/Aboriginal Healing Foundation (Truth and Reconciliation Commission of Canada, 2012) many had begun to gain insight into their anger and emotions and begin the road to healing, including reconnection with children and family members.

One ICM AB group man who was now more than 55 years old, discussed how he grew up very angry, used to fight a lot with other boys at school, and how Residential School affected him in his life. At the 18-month interview, he shared how he had started attending healing sessions with his children, and was learning to let go of anger from the past. *"Being able to, being able to say 'I love you' and 'I'm sorry' to my kids ... I've never said that to them you know, those types of things come out; that's what I mean, those types of fatherly qualities, manly qualities I should have had were always blocked by this anger in me."*

Improved Confidence and Self-Worth

Several participants who had supports conveyed an improved sense of confidence, purpose, and self-worth. Several HF participants said they now felt like they had a voice, were being heard, and recognized as having value. A woman in her mid-forties stated, *"I feel safer, I feel like there's, my voice is being heard now, I feel like I'm not just another statistic."* Similarly, a middle-aged man shared, *"I'm learning I have a voice and how to use it now."*

A father of three children spoke about how resuming his role as a parent and gaining custody of his youngest child, a four-year-old boy, had given him courage and determination, and was helping him to feel more confident. *"My son keeps me going and this program keeps me going."* (ICM AB participant)

A woman, who had been adopted as a child as part of the "Sixties Scoop," shared how her At Home support worker had contributed to her feeling of self-worth. *"He's also helped me to realize that, you know, I'm a human being, I'm gonna make mistakes and that's okay. As long as, you know, don't keep making the same mistakes, learn something from it."* (ICM AB participant)

Continued Struggles with Mental Health and Addictions

Some participants, particularly those in the TAU group, or those in the HF intervention group who had not found or been able to keep decent housing or establish supportive relationships, struggled to maintain the motivation to make changes and move forward with their lives. This may be because of unresolved mental health issues (such as depression). It may be also be due to difficulty staying away from the social environment that they see as contributing to their addiction. This is particularly true for those participants in the TAU group, or those in the HF group for whom the available housing choices did not allow them to move away from certain neighbourhoods, as described above.

Similarly, some participants, primarily in the TAU groups, continued to speak of or exhibit evidence of persistent struggles with mental health issues, and with obtaining appropriate mental health support. Some felt they had exhausted all options for support or had seemingly lost faith in the system. Disconnections, problems with access, or perceived lack of support from community mental health services were described as playing significant roles in these ongoing issues for some participants.

"I've given up on doctors and labels and whatnot and just done my own research on what I was told I had. But now it's also, I would like to like find out everything, because I know there's a lot more that I'm suffering from than what they're telling me ... 'Cause all they're diagnosing me with is borderline personality disorder, PTSD, and anxiety, but it's like, well, how come I get psychotic episodes?"

"So I'll make an appointment with my doctor and like [I will] not even show up. So, it's like, why should I? The doctor's not gonna listen to me, why should I go?"

Patterns of long-term drug and alcohol use and homelessness also continued to hinder some participants, even those in HF groups. Some participants had difficulty separating themselves from the life they had known for so many years and even with the support of a service team, were finding making changes challenging. An ICM participant said, *"a part of me, just won't let go of yesterday. So, I don't know if it's deep in me that, I, I don't feel that it is, it's just that, just doesn't wanna leave, but just, it's been a long road, 22 years without alcohol, but uh nine, going on nine years in the smoking the green for my arthritis, and sometimes to get high."*

CHAPTER 7

POLICY IMPLICATIONS

DISCUSSION OF LESSONS LEARNED AND IMPLICATIONS FOR PRACTICE AND POLICY (LOCAL AND PROVINCIAL)

Lessons Learned

The At Home/Chez Soi project has clearly demonstrated both substantially improved outcomes at a relatively small net cost to society (especially for the high need group) and a growing Housing First (HF) capacity that has been firmly established within Winnipeg. With substantial increases in housing stability and significant cost reductions for high users, the At Home/Chez Soi project has changed and continues to change lives while creating meaningful opportunities for recovery. Further, it must be noted that the project demonstrated that successful results for participants who are homeless does require collaboration among agencies and government departments. No one agency can address these complex circumstances and needs alone. Homelessness is preventable with the right approach, and HF, as delivered through the At Home/Chez Soi project, must be part of a comprehensive and long-term Manitoba strategy.

Through At Home/Chez Soi, Manitoba has developed an invaluable infrastructure for delivering services to a very challenging population. Until this point, the traditional systems had limited success in engaging these individuals. At Home/Chez Soi staff have been able to reach this vulnerable population and find creative ways to earn their trust. Teams adopted a service delivery system that embraced Aboriginal culture in its everyday work. Through this approach, people with lived experience of homelessness and mental illness have made a lasting impact on the program and participated at all levels of the project.

Critical to the learning from this project is the importance of knowing and recognizing the historical injustices and systemic issues and impacts these have had on the Aboriginal population in Manitoba. In working with Aboriginal people who are homeless, a broader social and historical lens must be integrated into the recovery work. Issues of racism, discrimination, systemic barriers, poverty, residential school impact, and institutional involvement with child welfare and justice have resulted in generational and multiple layers of trauma. Thus, services must also incorporate Trauma Informed Practice due to the Residential School impact and foster care and system involvement. HF with cultural adaptations is effective in reducing homelessness within the Aboriginal population. With the right kind of services and supports,

HF can make a difference; for example, many participants were able to stabilize, feel connected, and had an opportunity to pursue individual goals of recovery, education, and/or work and volunteering.

While maintaining adherence to the HF model, the At Home/Chez Soi project in Winnipeg has established a legacy of well-trained workers, engaged landlords, contributed to valuable research and insight, and fostered a spirit of cooperation among a diverse array of inter-sectoral partners. In addition, Manitoba Green Retrofit is firmly established and continues its work within the not-for-profit community.

The Winnipeg At Home/Chez Soi project is a Manitoba success story, addressing chronic issues facing our most vulnerable citizens. The HF model has helped Manitobans who are homeless and living with mental illness to dream of a brighter, more secure future that ensured secure housing, respected their culture, and took advantage of the lived experiences of Manitobans who are committed to making their dreams a reality.

The journey taken by the At Home/Chez Soi team set a path to recovery that began in Manitoba some five years ago when the first of more than 500 Manitobans enrolled in this landmark study. For many, this journey took them on the road to recovery with stable housing, the right supports around them, and a caring team ready to mitigate issues and obstacles that once prevented success for many. The At Home/Chez Soi project has made a valuable impact in the lives of many Winnipeg participants as is clear from this poignant participant comment:

"Now that my kids are in my life and [the At Home service team] brought me into the program and helped me out, I'm very grateful for whoever came up with this idea of (at) home, helping homeless people and I'm hoping and praying that they find other ways to keep things going like this, 'cause there is a lot of people still hurting right and ... I still see them out there ... and struggling."

Stable housing, along with supportive relationships, plays a critical reciprocal role in improving multiple health outcomes for this population.

...it must be noted that the project demonstrated that successful results for participants who are homeless does require collaboration among agencies and government departments. No one agency can address these complex circumstances and needs alone. Homelessness is preventable with the right approach, and Housing First, as delivered through the At Home/Chez Soi project, must be part of a comprehensive and long-term Manitoba strategy.

Implications for Policy and Practice

The At Home/Chez Soi project helped to meet a number of key policy priorities of the Government of Manitoba, addressing mental health and housing needs, poverty reduction and social inclusion, and engaging Aboriginal peoples. Additionally, At Home/Chez Soi delivered many of the tangible results specified within Manitoba's *Rising to the Challenge: Mental Health Strategic Plan*. This five-year plan calls for social inclusion of people living with mental health problems and illnesses through access to a range of recovery-oriented services. Through the Housing First model, this has been achieved by the At Home/Chez Soi project.

With respect to housing, At Home/Chez Soi complemented HOMEWorks!, Manitoba's housing strategy and policy framework to reduce and prevent homelessness and connect people who are homeless – including those with mental health programs and illness – with stable housing and supports. As well, developing Manitoba Green Retrofit (MGR) and Housing Plus have been significant components of the At Home/Chez Soi project. MGR will be one of the project's legacies and has developed, as a result of their experience with the project, other services for housing and landlords such as the Bug and Scrub program. This is a unique innovation of the Winnipeg site.

At Home/Chez Soi also supported key pillars of ALL Aboard: Manitoba's Poverty Reduction and Social Inclusion Strategy. This includes providing safe, affordable housing in supportive communities, and providing accessible, coordinated services for those most in need. Further, the impact of lessons learned from At Home/Chez Soi has implications to inform policy and practice far

beyond preventing homelessness. The HF model and the cross-jurisdictional learning that has occurred as a result of this project has potential to further inform health, social services, housing systems, and approaches to addictions treatment and work with older adults. For example, future policies could include flexible funding formulas (rent supplements and other) in order to secure various housing options and to create incentives for landlords to provide multiple units to participants who are homeless and who lack a solid reference and credit history. Finally, At Home/Chez Soi met Manitoba's strategy for engaging Aboriginal peoples by supporting those with mental illnesses to find stable housing, health, and social supports; employing and training Aboriginal support workers in the Housing First model; and using a traditional Aboriginal approach to care.

The At Home/Chez Soi legacy must be in leveraging the leadership of the Government of Manitoba that recognizes that HF works in this province because Manitobans have helped to adapt Housing First and ensure that it is a demonstrated approach in our province. The Winnipeg At Home project offers unique learning and experience that can be shared and used by other communities and provinces, particularly around the application of HF for individuals of Aboriginal descent. Further, a HF toolkit has been developed that can help to address distinctive circumstances of Aboriginal clients.

Finally, the Winnipeg research team has received funding to continue follow-up of the Winnipeg sample such that more can be learned about longer-term outcomes of HF in this city.

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APPENDIX 1

METHODS

Housing First (HF) creates a recovery-oriented culture that puts consumer/tenant choice at the centre of all its considerations with respect to the provision of housing and support services. It operates on the principle that all individuals who are homeless and living with mental illness should be offered the opportunity to live in permanent housing of varying types that is otherwise available to people without psychiatric and other disabilities, or drug and/or alcohol addictions. Assertive in-reach and outreach identifies and engages potential participants.

The At Home/Chez Soi study design is a *randomized controlled pragmatic field trial*. *Randomized* means that participants were put into the HF intervention and Treatment as Usual (TAU) groups by chance. A computer program was used to assign participants to the study groups at random, with no influence by the study investigators, service providers, sponsors, or anyone else. By *controlled* we mean that a “control” or comparison group that does not receive the intervention is used to make sure that any changes observed are due to the intervention and not some other influence. The term *pragmatic* means that the study involved individuals that would ordinarily present for a HF service in practice and that the services they and the TAU group received may vary as they would in real world circumstances. Finally, by *field trial* we mean that the intervention occurred in the same settings that the services might later be implemented if found to be effective. The study was also, by design, “multi-site” – that is, it was conducted in multiple sites – four larger urban settings and one smaller urban/rural setting, such that more could be learned about how HF programs fit or can be adapted to local contexts (*Goering PN, Streiner DL # See <http://bmjopen.bmj.com/content/11/2/e000323.full>*).

How were Data Collected and How Many Participants Completed Data Collection?

Two categories of participants were involved in this study. The majority of participants (n=513) were adults who were homeless. The second category includes project stakeholders who have been involved in the development and implementation of the project (n=40).

Adults who were Homeless

Criteria for inclusion in the project was as follows: (1) legal adult status (age 18); (2) met definition of “absolute homelessness” or “precariously housed”; (3) presence of any mental disorder with or without a concurrent substance use disorder. (N.B. Formal diagnosis was not required at time of entry into the project.)

Exclusion criteria: Failure to meet any of the inclusion criteria and if any of the following conditions are met: (1) inability to communicate in English; (2) incarceration or institutionalization (current or imminent); or, (3) refusal to comply with the research protocol; (4) inability to give informed consent.⁶

Data Collection

Interviewers from the research team met with all participants (n=513) to collect survey data every three months for two years after their enrolment in the study. A representative subset of participants (n=45) participated in narrative interviews at one and 18 months after enrolment.

Project Stakeholders

Individuals who were instrumental in the development and implementation of this project (housing and service providers, researchers, decision makers, project team members, landlords) were asked to participate in an individual interview, talking circle, or focus group in order to identify challenges and key success factors.

⁶ In rare cases where participants are legally unable to give their informed consent, the research team sought authority from a Legal Decision-maker or a Public Trustee.

APPENDIX 1A

KEY DEFINITIONS

Eligibility

Inclusion Criteria:

- Legal adult status (aged 18 or older/19 in British Columbia)
- Housing status as absolutely homelessness or precariously housed*
- The presence of a serious mental disorder[^] with or without a co-existing substance use disorder, determined by DSM-IV 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 nighttime residence is supervised public or private emergency accommodation (e.g., shelter, hostel).ⁱⁱ 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, in order to meet the criteria for inclusion, precariously housed individuals in the past year have had two or more episodes of being absolutely homeless, as defined above.

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).

References for Appendix 1a

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APPENDIX 2A

ADDITIONAL SOURCES

Winnipeg Site Cultural Adaptations to Implementing and Delivering Housing First

- Involvement and engagement of the Aboriginal community and organizations at all levels of the project's implementation, delivery, and decision making, including Site Coordination, Housing Supports & Service Teams, Research and Advisory Committees.
- The establishment of a Cultural Lens Committee comprised of Elders & Traditional Teachers was unique to Winnipeg. This Committee provided cultural advice, input, and guidance to the project and to the Mental Health Commission of Canada (MHCC) team.
- The establishment of the Lived Experience Circle (LEC), of whom the majority were Aboriginal participants who brought their voices and expertise as Aboriginal people with lived experience to the project.
- All three service teams integrated an Aboriginal Holistic Approach in delivering Housing First to participants based on the Seven Teachings and/or Medicine Wheel Approach.
- All staff from all three service teams participated in cultural ceremonies and sharing and teaching circles with Elders and Traditional Teachers who provided knowledge in Aboriginal world views, values, and approaches in working with AH/CS participants.
- Elders and Traditional Teachers were integrated as part of the services and programming offered to participants (i.e., ceremonies, teachings, feast, gathering, and one-on-ones).
- The At Home/Chez Soi project held many events in Winnipeg for key stakeholder groups and participants to promote inclusivity and knowledge exchange, incorporating cultural protocols and ways of doing things (e.g., the Sharing Circle was used to disseminate research findings to participants; Elders were included at events to open and close with a traditional prayer; gatherings and ceremonies were conducted at various times of the year to celebrate and honour the project's work and success: i.e., The 4 Directions and Pipe Ceremonies conducted by Elders; The Find the Good Workshop; and, the Seasonal Feasts and Gatherings held for Participants).

Lucille Bruce,

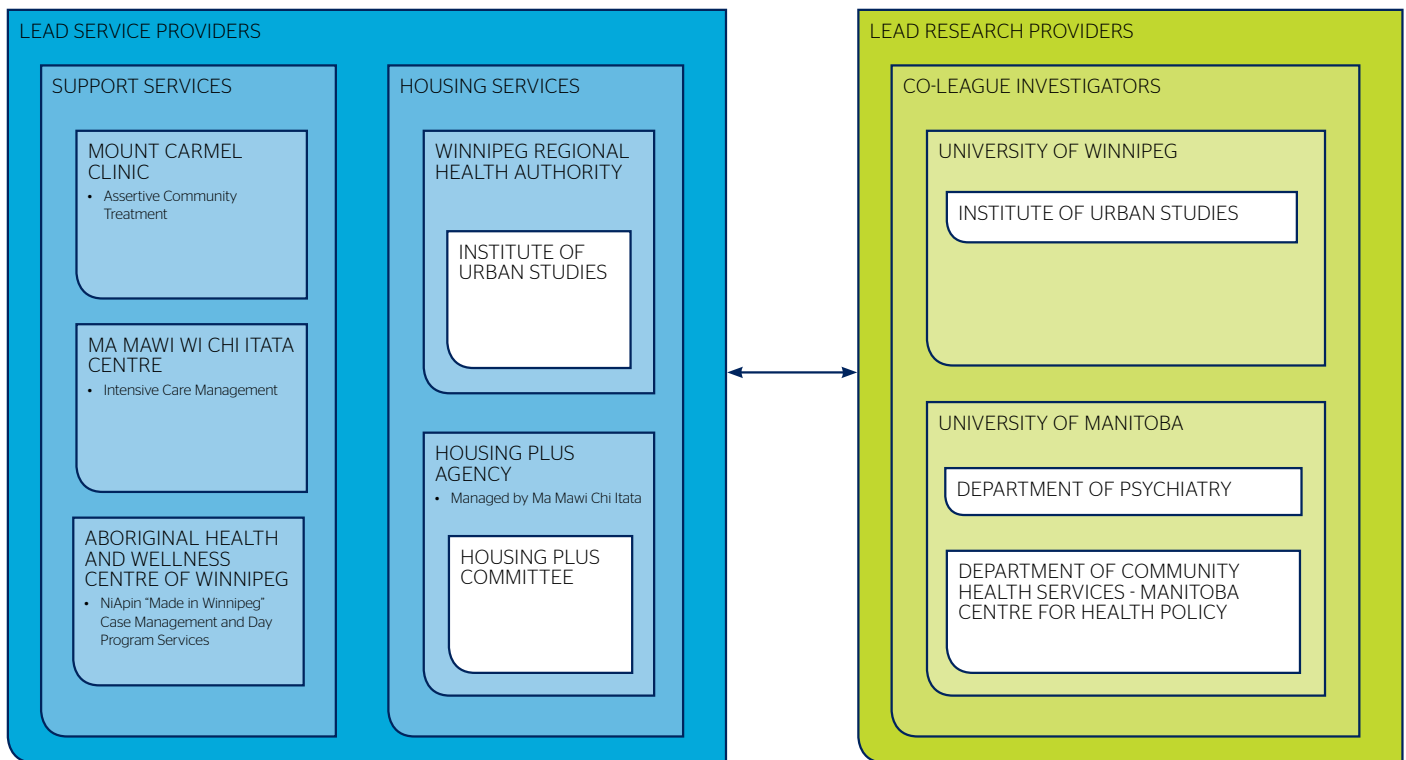
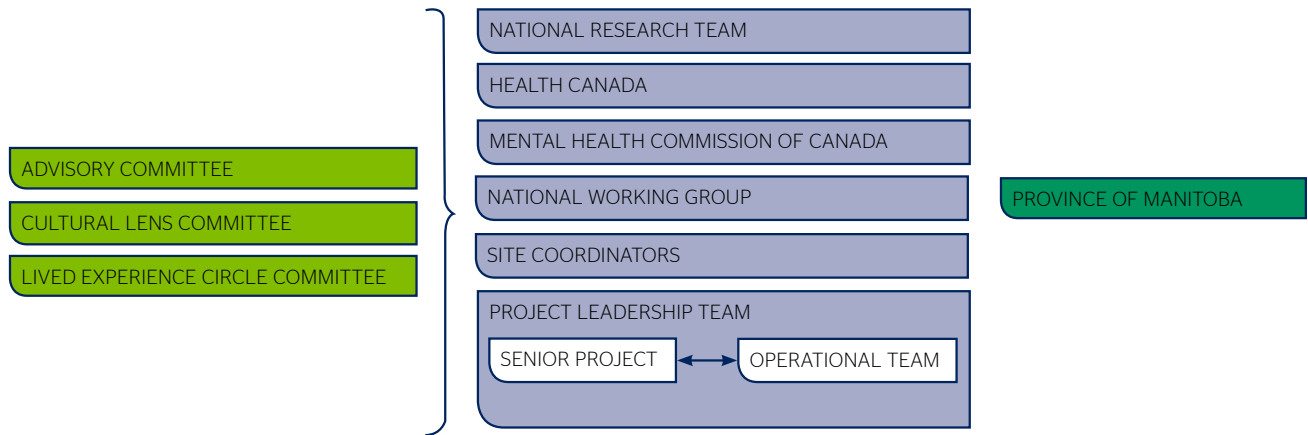
MHCC Housing First Aboriginal Special Advisor (and former Winnipeg Site Coordinator)

October 10, 2013

APPENDIX 2B

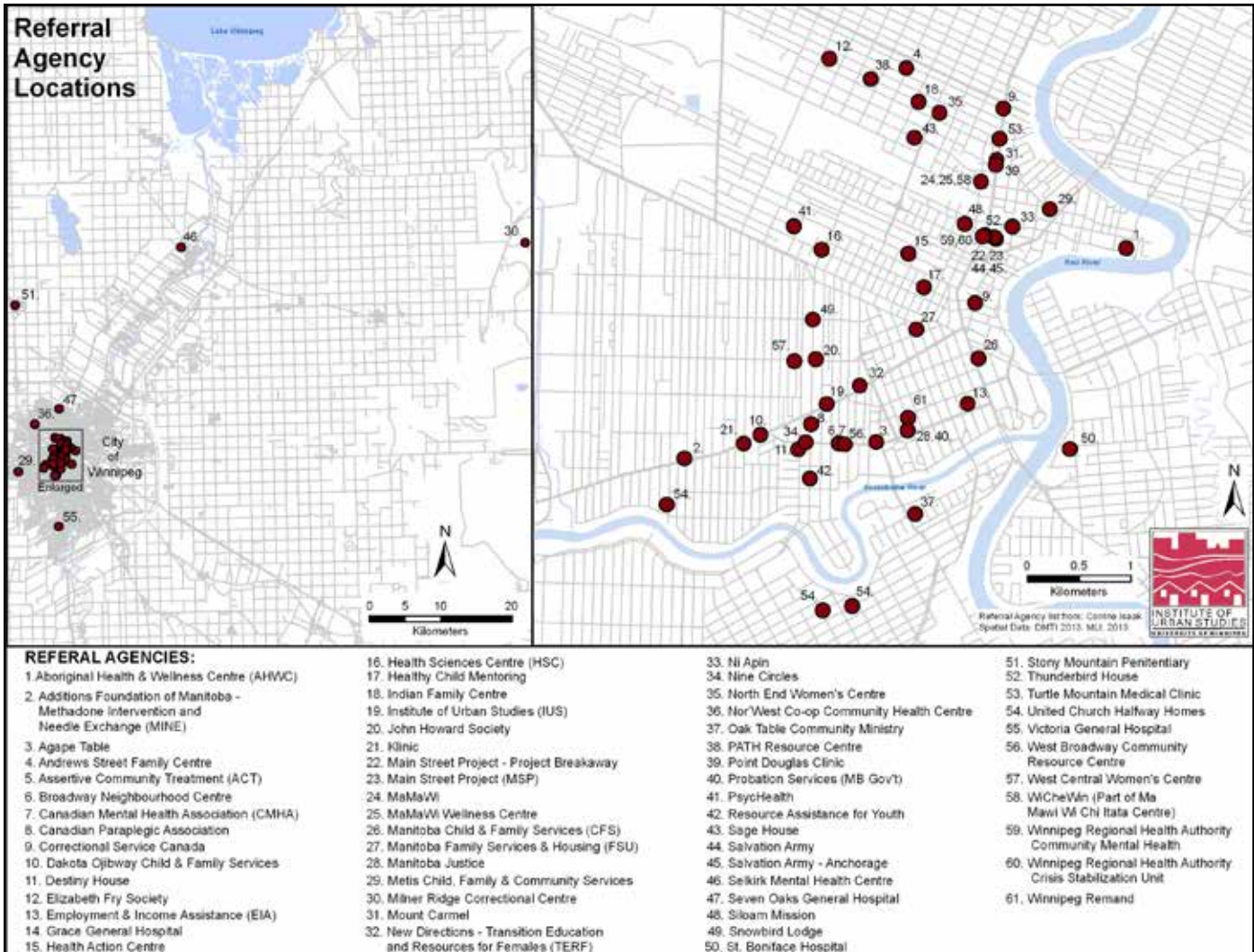
PARTNERSHIP STRUCTURE

Project Partnership Structure | MHCC Research Demonstration Projects



APPENDIX 3

MAP OF REFERRAL SOURCE LOCATIONS



APPENDIX 4

PAST AND CURRENT PERSONAL, HEALTH AND SOCIAL CIRCUMSTANCES – WINNIPEG*

	TOTAL SAMPLE N=513 %	ACT ANALYSIS N=199 %	ICM ANALYSIS N=314 %
NEED LEVEL # (determined by study screening)			
High need	39	100	0
Moderate need	61	0	100
Adverse Childhood Experiences (ACE) Mean score (out of a possible 10)	6	6	6
COGNITIVE IMPAIRMENT			
Got extra help with learning in school	50	52	48
Has a learning problem or disability	33	37	30
DIAGNOSIS AT ENROLMENT			
Psychotic disorder	28	47	16
Non-psychotic disorder	86	79	90
Substance-related problems	77	80	76
SUICIDE RISK AT ENROLMENT Moderate or high	41	43	39
COMMUNITY FUNCTIONING AT ENROLMENT (rated by interviewers)			
Average MCAS score % (lowest and highest scores)	60 (37 - 78)	55 (37 - 74)	63 (37 - 78)
HOSPITALIZED FOR A MENTAL ILLNESS [§] (for more than six months at any time in the past five years)	5	10	1
HOSPITALIZED FOR A MENTAL ILLNESS [§] (two or more times in any one year in the past five years)	37	54	24
SERIOUS PHYSICAL HEALTH CONDITIONS			
Asthma	26	32	23
Chronic bronchitis/emphysema	16	15	16
Hepatitis C	20	24	18
Hepatitis B	2	2	3
HIV/AIDS	4	5	4
Epilepsy/seizures	15	23	10
Heart disease	5	5	5
Diabetes	12	16	9
Cancer	3	4	3
TRAUMATIC BRAIN/HEAD INJURY Knocked unconscious one or more times	83	80	84
JUSTICE SYSTEM INVOLVEMENT (arrested > once, incarcerated or served probation in prior six months)	35	41	31
JUSTICE SYSTEM INVOLVEMENT TYPES			
Detained by police	29	40	22
Held in police cell 24 hours or less	34	51	30
Arrested	25	29	23
Court appearance	27	30	25
Attended a justice service program	11	15	8

	TOTAL SAMPLE N=513 %	ACT ANALYSIS N=199 %	ICM ANALYSIS N=314 %
VICTIMIZATION			
Theft or threatened theft	41	49	35
Threatened with physical assault	55	59	52
Physically assaulted	51	55	48
LACK OF SOCIAL SUPPORT			
Lacking a close confidante	55	55	55

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

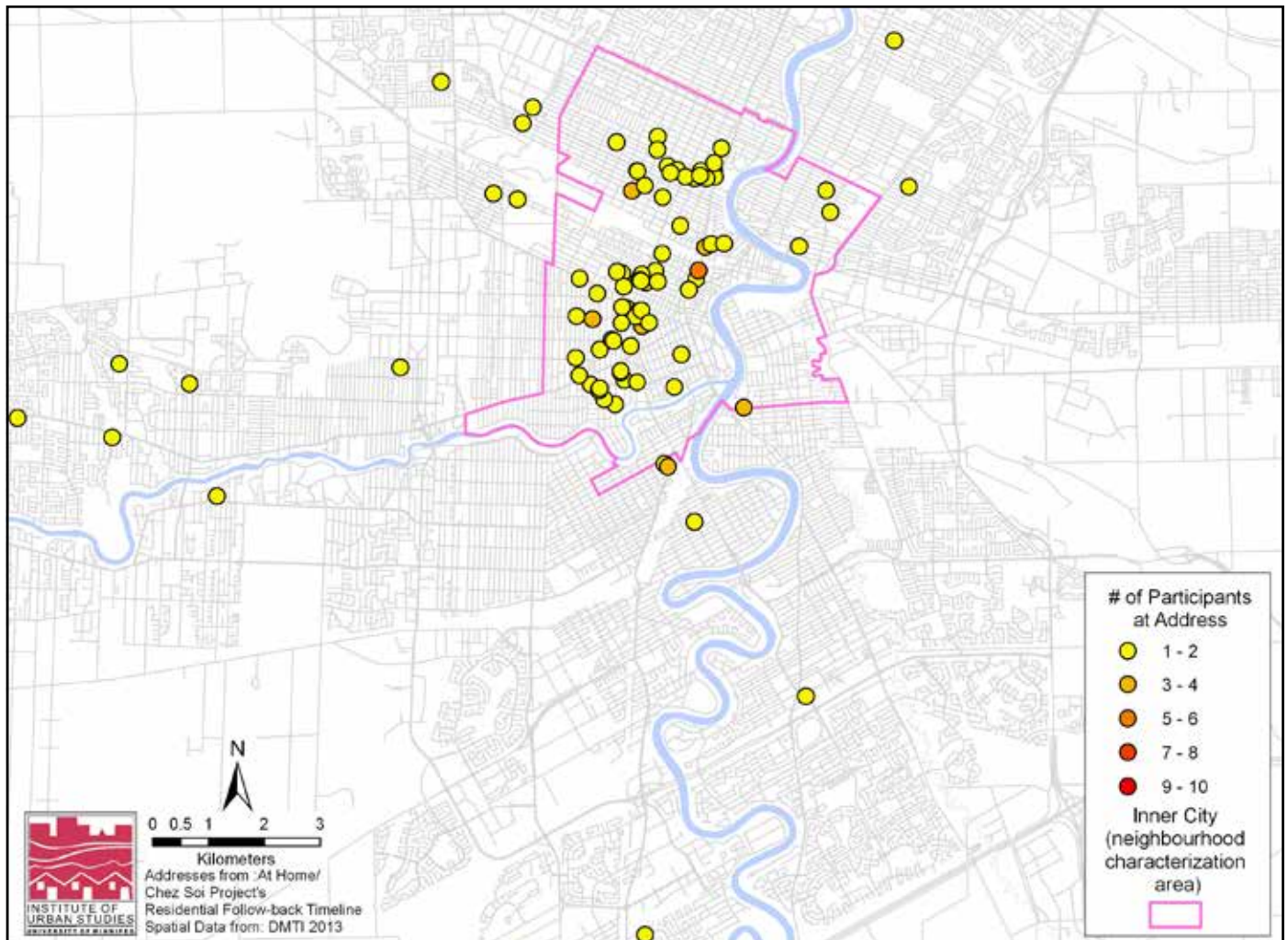
^{*} Multnomah Community Ability Scale - higher scores indicate better functioning; a score of 62 and below represents moderate to high disability or moderate to poor functioning; items include daily living independence, money management, coping with illness, and social effectiveness ;

[‡] Self-report of psychotic disorders and related hospitalizations are likely to be under-estimates due to the nature of the illness.

APPENDIX 5

MAP OF WINNIPEG HF PARTICIPANT RESIDENCES

(March 2013)



APPENDIX 6

SITE SPECIFIC SUB-STUDIES

A. Local Studies

1. A History In-Care Predicts Unique Characteristics in a Homeless Population: Findings from the Winnipeg Site Mental Health Commission of Canada Homelessness Study. Child Abuse and Neglect (in press) (Leslie E. Roos, Jino Distasio, Shay-Lee Bolton, Laurence Y. Katz, Tracie O. Afifi, Corinne Isaak, Paula Goering, Lucille Bruce, Jitender Sareen)

Objective: While multiple studies of people experiencing homelessness report an increased prevalence of a history in care, there is a dearth of information on associated outcomes or relevant demographic profiles. This information is critical to understanding if certain individuals are at elevated risk or might benefit from specific intervention. Here, we investigate how a history in care relates to demographics and multiple outcome measures in a homeless population with mental illness.

Methods: Using the Mini International Neuropsychiatric Interview (MINI), the Short-Form 12, and a trauma questionnaire, we investigated differences at study entry in demographics and length of homelessness in the At Home/Chez Soi trial (N=504) Winnipeg homeless population with and without a history in care.

Results: Approximately 50 per cent of the homeless sample reported a history in care. This group was more likely to be young, female, married or cohabitating, of Aboriginal heritage, have less education, and have longer lifetime homelessness. Individuals of Aboriginal heritage with a history in care were more likely to report a familial history of residential school. Individuals with a history in care experienced different prevalence rates of Axis I disorders. Those with a history in care also reported more traumatic events (particularly interpersonal).

Conclusions: A distinctive high-risk profile emerged for individuals with a history in care. Sociocultural factors of colonization and intergenerational transmission of trauma appear to be particularly relevant in the trajectories for individuals of Aboriginal heritage. Given the high prevalence of a history in care, interventions and policy should reflect the specific vulnerability of this population, particularly in regards to trauma-informed services.

2. DeBoer, T et al.

Correlates of Volatile Substance Use in an Adult Homeless Sample in Winnipeg

Objective: To examine the prevalence of volatile substance use (VSU) in a sample of homeless and precariously housed individuals in Canada. To study socio-demographic, traumatic and residential school history characteristics, mental disorders, and physical health conditions associated with solvent use in an adult sample.

Method: Using baseline data from the Winnipeg, Manitoba site of the At Home/Chez Soi project, socio-demographic factors, traumatic experiences, residential school history, Axis I mental disorders, and physical health conditions were evaluated in relation to the use of solvents. Multiple logistic regression was the primary means of analysis.

Results: Five hundred and four adults who were homeless were included in the sample. The prevalence of solvent use was 6.5 per cent (n=33). Individuals who reported use of solvents were statistically more likely to be married or cohabitating with a partner, have a longer length of homelessness, to have experienced a greater number of traumatic events in their lifetime, have a father who attended residential schools or not know if their father attended residential school, to have more Axis I disorders, and to have more physical health conditions than those who did not use solvents. Statistically significant odds ratios range between 2.12 and 5.58 ($P < 0.05$).

Conclusions: This study highlights correlates of VSU in an adult Canadian sample. These findings indicate that this population may require more extensive health services than those who do not use solvents and may be at higher risk for suicidal behaviour and mortality.

3. DeBoer, T. et al. (MA thesis)

Constructing Hope in Challenging Spaces: Narratives by Health Professionals on Issues of Solvent Use

The process of recovery from addiction is a multifaceted process that involves the efforts of clients, professionals, and the broader community. Additional challenges to recovery are present for individuals who use solvents. This study investigates how professionals involved in the provision of services to clientele who use solvents understand the process of healing in their collaborative work. Using a narrative methodology, semi-structured interviews were conducted with professionals employed in providing recovery-based services to individuals who use volatile solvents. The stories of these professionals demonstrate how they view their clients as “just like everyone else” despite what the dominant cultural story says about their possibilities for recovery. The professionals told stories which are in extreme opposition to the story of dominant culture and involved groupings of “us” (professionals) versus “them” (others). These stories, and how they were told, are discussed in relation to hope for professionals who provide health and housing services.

4. Navigating aging and homelessness: A qualitative exploration of the new face (Reynolds et al.)

With older adults who are homeless having been previously neglected in homelessness research and policy, recent research has begun to focus on the unique experiences of this group. In the United States, the proportion of adults who are homeless aged 50 years and older has nearly tripled in the past decade, increasing from approximately 11 per cent to 30 per cent of the homeless population. Older adults who are homeless have high rates of health problems, substance use, and cognitive impairment. Although research has begun to explore the changing face of homelessness, there is a scarcity of research examining the experiences of older adults who are homeless. Thirteen participants (10 males and three females), ages 50 to 60, recruited from the larger At Home/Chez Soi project in Winnipeg, Manitoba, Canada, completed individual interviews exploring their experiences of homelessness. Most participants reported lifelong intermittent homelessness, beginning in their teenage years, young-adulthood, or middle age. Participants' pathways to homelessness were driven by alcohol and the loss of important relationships, economic instability, mental health problems, and housing inequalities. Authors identified five main themes that captured the experience of homelessness for older adults. These include worsened health, lack of meaning in life, shame, self-reliance, and the challenge of disentanglement from the cycle of homelessness. This study provides insight into the experiences of older adults who are homeless in Canada. Findings suggest a need to focus on age-based care in order to meet the unique needs of older adults who are homeless.

B. Site-Specific Administrative Data Findings

Research Demonstration Project in Mental Health and Homelessness

(Winnipeg): 24-Month Administrative Health Outcomes Study (Katz LY et al)

The purpose of the study is to compare rates of health care service utilization and mental health outcomes over a 24-month period for a sample of 513 participants in the Winnipeg component of the Mental Health Commission of Canada's mental health and homelessness randomized controlled trial based on the administrative data of these participants housed at the Manitoba Centre for Health Policy (MCHP). The objectives of the study include: (1) to describe the demographic (i.e., age, sex, marital status) distribution, income assistance utilization, physical and mental health conditions, prescription use, pattern of contact with the health care system, emergency room service utilization, frequency of suicide attempts and completions, and overall mortality, for the full sample and (2) to compare the rates of health care service utilization and health outcomes between the Housing First intervention and Treatment as Usual groups over two years in this randomized sample.

The intention of this project is to provide comprehensive, administrative findings on the differences in health care service utilization and health outcomes among this high-risk population of people experiencing homelessness with mental health concerns. Given the limitations of self-report data, this project will inform the health risks and benefits; the costs and outcomes associated with this intervention from an administrative data vantage point.

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