MONCTON FINAL REPORT

At Home/Chez Soi Project

Mental Health Commission of Canada

Commission de la santé mentale du Canada

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AT HOME/CHEZ SOI PROJECT: MONCTON SITE FINAL REPORT

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MAIN MESSAGES
FROM THE MONCTON AT HOME/CHEZ SOI PROJECT

1 **Housing First can be implemented in a small city and a rural region.** The Moncton site study tested Housing First (HF) in the context of a small city and a rural region. Moncton is a fast-growing, bilingual city of 139,000 where homelessness tends to be mostly invisible. The Moncton site sample included 201 individuals (35 per cent female), more than half of whom were middle-aged. Almost all participants were born in Canada, four per cent were Aboriginal, and three per cent reported another ethnocultural status. Fifty-six per cent of participants were absolutely homeless when recruited; on average, participants had spent more than four years homeless in their lifetime. All participants presented with mental health problems (psychotic disorders: 23 per cent; non-psychotic disorders: 86 per cent; substance-related problems: 73 per cent). Most participants had more than one disorder and most had concurrent mental health and substance related problems.

2 **HF is successful in ending homelessness in this context.** HF participants demonstrated a consistently higher percentage of time housed (i.e., > 85 per cent) than the control group (TAU) participants throughout the study. As well, a higher percentage of HF participants were housed continually for the last six months of the study (i.e., 74 per cent of HF participants versus 30 per cent of TAU participants). Housing quality (unit and building combined) was similar for HF residences compared to TAU residences, and the quality of HF units was much less variable than the quality of TAU units. Findings from the Moncton site demonstrate the feasibility of implementing HF in a rural region where individuals transitioned into independent living from Special Care Homes, living with families, or being homeless or precariously housed. It yielded comparable housing outcomes to those seen in urban settings.

3 **HF resulted in a decreased use of services, overall.** Throughout the study, service use decreased in both groups. After 24 months, the HF group was receiving more visits from service providers than TAU. However, the TAU group was making more frequent use of visits to service providers, outpatient clinics, and drop-in centres.

4 **HF facilitates an improved quality of life and other positive changes beyond improved housing stability.** HF services produced a positive effect on perceived quality of life; the HF group reported greater improvement in this area than the TAU group over the course of the study. Both groups showed the same level of improvement in community functioning over the course of the study. Qualitative interviews with a select sub-sample of participants from the two groups (N = 42) revealed a majority of the HF group (60 per cent) reporting positive changes in their lives. In contrast, a minority of TAU participants (30 per cent) described themselves experiencing positive trajectories since entering the study.

5 **HF is a wise investment.** The HF program costs averaged $20,771 per person per year. Over the two-year period, every $10 invested in the program resulted in an average savings in health care, social services, and justice use of $7.75 as a result of decreased hospitalization, office visits to community-based services, and stays in detox facilities.

6 **A Peer Supportive Housing Program may improve outcomes for clients with additional needs.** A Peer Supportive Housing Program was piloted and demonstrated that this can be an effective back-up plan for individuals who do not find stable housing within the Housing First program.

7 **HF is a very good choice for practice and policy.** The findings from the Moncton site demonstrate the feasibility and value of implementing HF in a small Canadian city and in a rural region. Findings from the Moncton site also show only a small outlay of supplementary net resources are required to implement HF in a small Canadian city once savings in health, social, and justice service use are considered.

EXECUTIVE SUMMARY
FROM THE MONCTON AT HOME/CHEZ SOI PROJECT

Program Implementation

At Home/Chez Soi was designed to help to identify what works, at what cost, for whom, and in which environments. The Moncton site tested Housing First (HF) compared to treatment as usual (TAU), namely the area's existing approach and available services, in the context of a small city and a rural region. The site implemented HF with Assertive Community Treatment (ACT) services delivered to people with both high and moderate levels of need. Moncton is a fast-growing, bilingual city of 139,000 inhabitants where homelessness tends to be less visible than in big cities. This document builds on the findings reported in the national report by providing greater detail about the local findings for the Moncton site, and the implications for local practice and policy.

Moncton participants

A total of 201 individuals were randomly assigned to either receive HF (N = 100) or TAU (N = 101). Approximately two-thirds of the Moncton participants were middle-aged (i.e., 35 years old or older: 67 per cent) and predominantly male (65 per cent). Almost all participants (99 per cent) were born in Canada. Four per cent reported that they are Aboriginal, and three per cent reported another ethnocultural status. Only four per cent of participants were married or living common-law. Although 37 per cent reported having children, very few of those children currently lived with them. Five per cent of participants reported wartime service. Numerous challenges contributed to the difficulties participants experienced in their lives. For example, 58 per cent did not complete high school, and 15 per cent reported that their prior month income was less than $300. While 91 per cent were unemployed at the time of study entry, 69 per cent have worked steadily in the past, which suggests a potential for re-employment after stabilization in housing. Most participants were recruited from shelters or the streets, with 56 per cent absolutely homeless and 44 per cent precariously housed. The longest single past period of homelessness was about 25 years and the average total time homeless in participants' lifetimes was approximately four years. At entry, participants reported symptoms consistent with the presence of the following conditions: 23 per cent psychotic disorder, 86 per cent non-psychotic disorder, and 73 per cent substance-related problems. More than 60 per cent presented with mental health and substance use problems. With regards to attrition of the sample over time, 83 per cent of the sample was available for follow-up at two years, including 90 per cent of the HF group and 75 per cent of the TAU group.

Rural participants

The rural arm included participants who were either living in Special Care Homes, with their families, precariously housed, or homeless upon entry to the study. Twenty-four participants received Housing First and ACT services within rural communities in the southeastern region of New-Brunswick who were later matched with 19 participants who continued to receive services as usual. The rural study sample is predominantly male (72 per cent) and francophone (79 per cent) with a mean age of 38 years. Most participants had never experienced homelessness as defined in the present study. Similar to the Moncton sample, 60 per cent did not complete high school. However, 67 per cent were unemployed at the beginning of the study, which is significantly lower than what is noted in the Moncton arm. At study entry, 30 per cent reported symptoms consistent with a psychotic disorder. Substance-related problems were substantially lower in the rural sample with only 35 per cent reporting substance-related problems. Similarly, alcohol-related problems were reported by only 30 per cent of rural participants.

Findings for the Moncton Group

Housing outcomes

HF participants demonstrated a higher percentage of time being stably housed than TAU participants throughout the study. The percentage of time housed for HF participants remained consistently high (i.e., > 85 per cent) for the duration of the study. Almost three-quarters (73 per cent) of the HF participants were housed all of the time in the last six months of the study, compared to only 31 per cent of the TAU group. Housing quality (unit and building combined) was similar for HF residences compared to TAU residences and the quality of HF units was much less variable than the quality of TAU units.

Social and health outcomes

Although the groups had similar baseline scores, the HF group reported greater overall quality of life, on a self-report measure, than the TAU group throughout the follow-up period. In addition to greater overall quality of life, the HF group specifically reported greater quality of life in sense of safety, leisure activities, living situation, and financial domains. The two groups did not differ in community functioning, even after 24 months of intervention. Note that community functioning is rated by an observer, and not self-rated by the participant.

Service use outcomes

Service use tends to decrease over time for both groups. Throughout the study, the frequency of emergency room visits was almost equal for both groups. Phone conversations with service providers and visits to food banks were more frequent in the HF group at six and 12 months, but were approximately on par with the TAU group by the 24-month mark. Also at 24 months, service use was heavier for TAU participants for visits to service providers, and outpatient clinics.

Costing outcomes

The intervention costs $20,771 per person per year on average. These costs include salaries of all front-line staff and their supervisors, additional program expenses such as travel, rent, utilities, etc., and rent supplements. Over the follow-up period, by comparing the costs of services incurred by HF participants with those of TAU participants, we found that the intervention resulted in average reductions of $16,089 in the cost of services. Thus, every $10 invested in services resulted in an average savings of $7.75. The main cost offsets were office visits in community health centres and with other community-based providers ($8,473 per person per year), hospitalizations in medical units in general hospitals ($4,220 per person per year) and stays in detox facilities ($2,731 per person per year). Other cost offsets and increases were all less than $1,000 per person per year.

Findings for the Rural Group

For the rural arm of the project, 100 per cent of the participants in both groups were stably housed during the first three months of the study. After 18 months, the HF participants had been stably housed 80 per cent of the time while the TAU group had been housed 84 per cent of the time. The overall quality of life for the HF participants and TAU participants in the rural arm remained the same and stable over the 18 months of the study. As well, both groups were assessed as having similar and high levels of community functioning throughout the study.

Other Findings

Fidelity assessments

The fidelity assessments in Moncton found that the Moncton site program (i.e., in Moncton and the rural arm) achieved very good fidelity to the HF model. Two fidelity assessments were completed in Moncton, in August 2010 and again in January 2012. The program was functioning in alignment with HF recovery-oriented philosophy and practices.

Qualitative findings from Moncton

Qualitative interviews were conducted with 10 HF participants and 10 TAU participants in Moncton at study entry, and eight HF participants and eight TAU participants at the 18-month follow-up. Overall, HF participants in Moncton tended to present a more positive perspective on their lives that included perceptions of improvement and a hopefulness related to the future when compared to TAU participants in Moncton. HF participants also attributed improvements they had experienced over the course of the study to their receipt of the combination of housing and support. The diversity of and access to regular services was described by HF participants as making it possible for them to attain a better balance and achieve specific objectives in their lives. For example, these included such objectives as not using drugs anymore, going back to school, or making a budget. In contrast, TAU participants who were able to access housing, but without receiving consistent support, described encountering significant and ongoing difficulties related to their mental illness. Other TAU participants recounted how they received services but without stable housing, and this prevented them from moving forward.

Qualitative findings from the rural region

Qualitative interviews were also conducted with 11 HF participants and 11 TAU participants in the rural region at study entry and 11 HF participants and eight TAU participants at the 18-month follow-up. Overall, the qualitative interviews with rural participants revealed greater recovery in the HF group over the TAU group. Most participants in the HF group seemed to report improvement from the first to the last interview, while no change was described by the TAU group. Changes in the HF group seemed to reflect a move towards greater autonomy, increased empowerment, and a brighter outlook on the future. In contrast, participants in TAU who

did well early in the study were still doing well, and participants who struggled initially were still struggling at the end of the follow-up period. In general, many of the TAU participants appeared to remain in a precarious state over the course of the study that resulted in an ongoing dependency on health and social services.

Peer supportive housing pilot program

The Moncton site also implemented a Peer Supportive Housing Pilot Program for those for whom the standard HF model did not lead to stable housing in the first year. Findings of an implementation evaluation of this pilot program showed that a more structured housing option could assist individuals with additional needs to achieve stable housing. A number of challenges were encountered with the program, most of which appeared to have been effectively resolved.

Implications for practice and policy

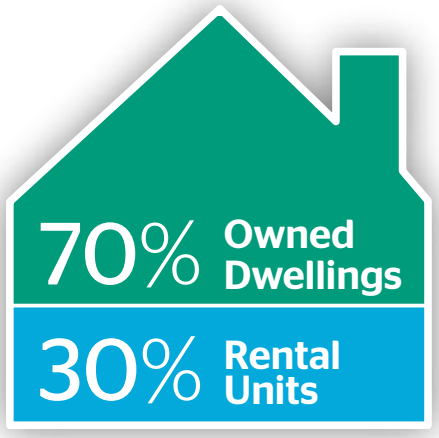
The findings from the Moncton site demonstrate the feasibility and value of implementing HF in a small Canadian city and in a rural region. The combination of study outcomes over a relatively short period of time in the areas of housing and quality of life suggest that HF can help support the community integration process for people with severe and persistent mental illness who have experienced long periods of marginal existence. Findings from the Moncton site also show that investments in HF are offset by significant savings in health, social, and justice services such that only a small outlay of supplementary net resources are required to implement HF in a small Canadian city.

CHAPTER 1
INTRODUCTION

Background and City Context

The Moncton site encompassed the Greater Moncton region, which includes the Cities of Moncton and Dieppe, and the Town of Riverview. The Greater Moncton area population in 2011 was approximately 139,000, having experienced a growth of 9.7 per cent between 2006 and 2011 (City of Moncton 2011).

The location of the rural arm of the Moncton site was in the southeast region of the Province of New Brunswick, notably in the counties of Kent and Westmorland. The area was within a 60-minute drive of Greater Moncton and covered a region stretching over approximately 2,000 square kilometers, including Shediac, and spanning from as far south as Cap Pele to as far north as Richibucto. This rural region is made up of a variety of small municipalities and service districts that range in population from a few hundred up to four or five thousand. There are approximately 40,000 people living in this rural area of the Southeast region of the province.



Housing in the Greater Moncton Region

Approximately 70 per cent of dwellings in the Greater Moncton region are owned, with the remaining 30 per cent being rental units. With respect to core housing needs, there have been positive improvements noted in housing adequacy, suitability, and affordability since 1991. In particular, the percentage of rental dwellings considered in "core housing need"[1] decreased from 33 per cent to 25 per cent over the 10-year period from 1991 to 2001 (Human Resources and Social Development Canada, 2007). The vacancy rate in the region at the time of the current study varied over the course of the study from 3.8 (2009) to 9.1 (2012) per cent (Canada Mortgage and Housing Corporation, 2013).

There have been some small, incremental increases in income assistance and the minimum wage. One of the significant gaps in policy that continues to affect the living conditions of many renters is the absence of provincial standards to regulate the safety and suitability of rooming and boarding houses. The Community Plan Assessment Framework for Moncton (Human Resources and Social Development Canada, 2007) identified approximately 15,500 individuals at potential risk of homelessness in the Greater Moncton area. These individuals were identified as living in substandard rental units (in core housing need), as well as experiencing significant financial demands related to covering their basic shelter and living costs (approximately 50 per cent of income dedicated to shelter/housing costs). Based on existing sources of data provided by emergency shelters, it is estimated that more than 700 unique individuals were homeless and stayed in shelters located in Moncton in 2011 (Greater Homelessness Moncton Steering Committee, 2012).

Appendix A provides definitions of key terms used in the demonstration project and referenced in the report.

Positive improvement: from 1991 to 2001, rental dwellings considered in "core housing need" dropped from 33% to 25%.

[1] A household is said to be in core housing need if its housing falls below standards in terms of adequacy, suitability, or affordability, and it would have to spend more than 30 per cent of its before-tax income to pay the median rent of alternative local housing that meets all three standards. (Cooperative Housing Federation of Canada, 2007).

CHAPTER 2
DESCRIPTION OF THE HOUSING FIRST PROGRAM AT THE MONCTON SITE

The main intervention for the Moncton site was a Housing First (HF) supported housing program based on the Pathways to Housing approach originally developed in New York City (Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005; Tsemberis, 1999; Tsemberis, 2010; Tsemberis & Eisenberg, 2000; Tsemberis, Gulcur, & Nakae, 2004). Specifically, the intervention included a combination of Assertive Community Treatment (ACT) and subsidized housing in the private rental market.

Assertive Community Treatment (ACT)

The target population for ACT at the Moncton site was individuals with persistent mental health problems and with either moderate need or high need as defined for the national study. The aim of the ACT team was to provide participants with needed treatment, rehabilitation, or support services to facilitate their successful functioning in the community.

Members of the ACT team were employees of the two Regional Health Authorities known as Horizon and Vitalité. For some positions, this has required personnel transfers within the Health Authorities, secondment from other public service departments, or the hiring of new personnel. The staffing level was set at 10 FTE and was composed of a mix of mental health disciplines that included a nurse practitioner, psychiatric nurses, occupational health therapist, home economist, social worker, physician clinical director, vocational counsellor, and consulting psychiatrists. The team also included peer support workers who are individuals with lived experience of mental illness and addictions, and a team leader with training in psychiatric rehabilitation who was available to provide clinical services to participants as needed.

The ACT team provided follow-up clinical services for 100 participants in the Greater Moncton area. The ACT services operated with a participant:staff ratio of 10:1 which is the standard for ACT. This ratio enables the delivery of intensive services. Members of the ACT team collaborated and supported one another in the provision of daily services to participants. This teamwork included sharing common roles and functioning interchangeably with respect to the execution of case planning and service delivery activities while still respecting areas of specialization and limitations associated with professional competencies. All team members had responsibilities related to participation in the delivery of core services including outreach and participant engagement, screening and comprehensive assessment, clinical treatment and counselling, case management and review, community service collaboration and consultation, and file management.

In addition, there were two rural service providers located out of the mental health clinic in Shediac (a nearby town with a population of 6,053 inhabitants) who worked in close collaboration with the ACT team in Moncton. The rural service providers supported 24 participants living in the southeastern New Brunswick region. Prior to being admitted for services from the rural service provider, participants lived either in Special Care Homes, with their families, in rooming houses, or were homeless. Upon admission into the program, participants in the rural region moved into their own housing to live independently in scattered site units.

The rural arm of the ACT team was intended to operate with a participant to staff ratio of approximately 8:1 which is a common standard for delivering ACT services in rural regions. However, the rural arm operated with two staff members, rather than three, for much of the period of the project, which effectively resulted in a participant:staff ratio of 12:1. Members of the rural ACT team collaborated and

The ACT team provided follow-up clinical services for 100 participants in the Greater Moncton area.

supported one another in the provision of daily services to participants in the same way as the urban team. Each participant was assigned a primary and secondary case manager from the rural ACT Team. The Physician Clinical Director located on the Moncton ACT team assumed primary responsibility for monitoring the status and response to treatment for the rural participants.

In line with the way ACT is delivered in the NYC Pathways to Housing model, the Moncton and rural members of the ACT team provided a complete range of services, including treatment of psychiatric and medical conditions, rehabilitation, crisis intervention, integrated addiction treatment (harm reduction approach), vocational assistance, as well as help with other needs identified by the participant. The service approach was informed by recovery principles, which are oriented to assisting participants to adopt valued social roles and become integrated in the community. Although the ACT team assisted participants to access needed resources in the community, they assumed the primary responsibility for providing most of their needed mental health and related services.

Upon admission to the ACT program, a service plan was developed in collaboration with the participant at the first meeting. The ACT team worked closely with a housing worker to help participants quickly find housing, where possible of their choice, which they could afford with the rent supplement. Although the Housing Worker was not a formal member of the ACT team, he or she worked closely with the team to assist participants in selecting housing, negotiating with landlords, moving into housing, and adapting to the new living situation as a tenant. The Housing Worker was also available to assist when problems were encountered with housing and/or with landlords.

In keeping with the Pathways HF program's voluntary treatment and harm reduction approaches, participants were required to have a minimum of one visit per week from an ACT team member. Otherwise, the participant had a choice around any additional contact or treatment and whether they abstained from substance use. Clinical services provided by the ACT team were organized around an individual's service plan, which was developed in collaboration with the participant to assist with their recovery.

Staff services were available from 8:30 a.m. until 10 p.m., seven days per week. Evening hours included the provision of outreach and crisis response, which were supported by the existing Mental Health Mobile Crisis Unit of the Regional Health Authority. The ACT team office for the Greater Moncton area was located in close proximity to the downtown core. The selected site was in a convenient central location to facilitate team members' contact with participants.

The ACT team held daily organizational meetings to review participants' progress and the outcomes of the most recent staff-participant interactions, including appointments, informal visits, or emergency after-hours responses. In addition, members collaborated to develop a team work schedule to coordinate key treatment and support activities for participants. This organizational meeting was held at the beginning of each work day and lasted for approximately one hour. The daily team work schedule provided a summary of all participant activities to be completed for the given day. Members of the rural team participated in these meetings by teleconference.

Subsidized Housing

Participants' housing was coordinated by the Housing Worker who was located at the United Way of Greater Moncton and Southeastern New Brunswick. In particular, the Housing Worker delivered this service component through the following steps: (1) identifying suitable private market housing units based on participants' personal preferences as much as possible, (2) accompanying participants to visit available apartments, (3) negotiating lease agreements with landlords, (4) helping participants move in and set up their apartments, (5) providing necessary support to assist participants to adapt to their new living situation, and (6) serving as a mediator between landlords and tenants if problems were encountered. The Housing Worker also attended ACT team meetings as necessary to participate in service planning for tenants.

A key feature of the HF approach was the provision of a rent supplement to ensure that participants paid a maximum of 30 per cent of their income for housing. Given the relatively high private market vacancy rate and the long waiting list for social housing in Moncton, all program participants moved into private market housing. The delivery of housing and support services was provided without any pre-conditions of housing readiness; however, participants had to be willing to have a reasonable portion of their monthly income allocated directly to cover rent expenses.

Appendix B presents the organizational chart for the At Home/ Chez Soi project in Moncton.

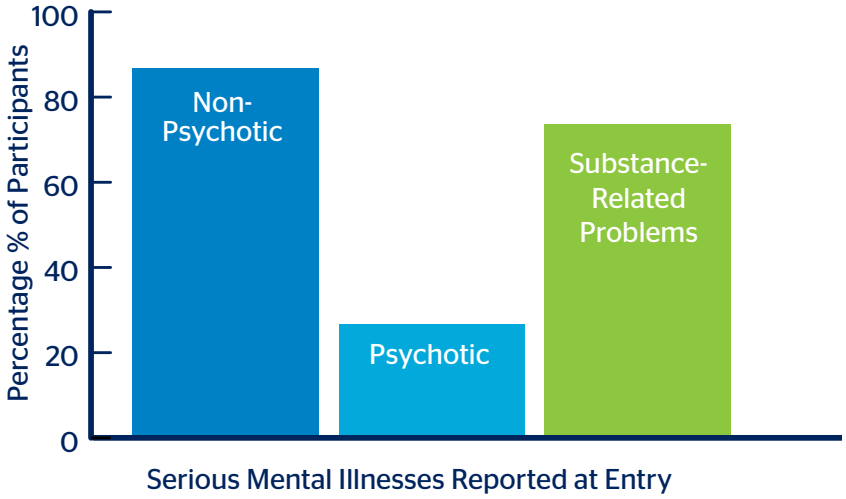
Appendix C provides an overview of the study design and methods.

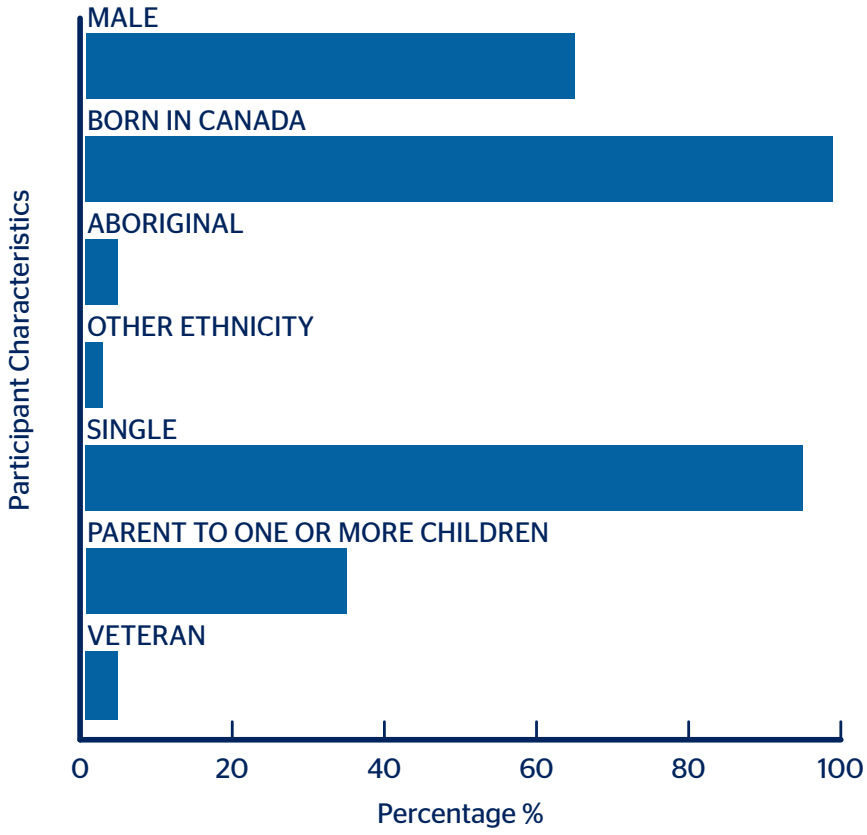
CHAPTER 3
PARTICIPANT CHARACTERISTICS

Moncton Sample

The Moncton sample reported here included all of the Housing First (HF) and Treatment As Usual (TAU) participants (*n* = 201), but not those from the rural arm. The characteristics of the participants in the rural arm are presented separately below. Table 1 provides a breakdown of the characteristics of the Moncton sample compared to the national sample. Approximately two-thirds of the study population was middle-aged (i.e., 35 years old and older: 67 per cent) and predominantly male (65 per cent). Almost all participants (99 per cent) were born in Canada. Four per cent reported that they were Aboriginal, and three per cent reported another ethnocultural status. Only four per cent of participants were married or living common-law. Thirty-five per cent reported having one or more children, however, very few of those children were living with them at the time of study enrolment. Five per cent of participants reported wartime service for Canada or an allied country.

Numerous challenges contributed to the difficulties participants were experiencing in their lives. For example, 58 per cent did not complete high school, and 15 per cent reported that their prior month income was less than $300. While 91 per cent were unemployed at the time of study entry, 69 per cent had worked steadily in the past, which suggests a potential for re-employment after stabilization in housing. Most participants were recruited from shelters or the streets, with 56 per cent absolutely homeless and 44 per cent precariously housed. The longest single past period of homelessness was about 25 years and the average total time homeless in participants' lifetimes was approximately four years.





At entry, participants reported symptoms consistent with the presence of the following conditions: 23 per cent psychotic disorder, 86 per cent non-psychotic disorder, and 73 per cent substance-related problems. Most participants presented with symptoms consistent with more than one condition, and more than 60 per cent presented with mental health and substance use problems. Additionally, more than 50 per cent of participants reported a serious physical health condition and 74 per cent reported a prior traumatic brain injury. Thirty-seven per cent reported having a learning problem or disability.

With regards to attrition of the sample over time, 83 per cent of the sample was available for follow-up at the study end-point, notably 90 per cent of the HF group and 75 per cent of the TAU group.

Table 1. Participant Demographic Characteristics — Moncton and National Samples

	MONCTON TOTAL SAMPLE N =201 %	NATIONAL TOTAL SAMPLE N =2148 %
AGE GROUPS		
34 or younger	33	33
35–54	60	57
55 or older	7	10
GENDER		
Male	65	67
Female	35	32
Other	<1	1
COUNTRY OF BIRTH		
Canada	99	81
Other	1	19
ETHNIC STATUS^		
Aboriginal	4	22
Other ethnocultural	3	25
MARITAL STATUS		
Single, never married	66	70
Married or common-law	4	4
Other	30	26
PARENT STATUS		
Any children	37	31
EDUCATION		
Less than high school	58	55
High school	23	19
Any post-secondary	19	26
PRIOR MILITARY SERVICE (for Canada or an ally)	5	4
PRIOR MONTH INCOME LESS THAN $300	15	24
PRIOR EMPLOYMENT (worked continuously at least one year in the past)	69	66
CURRENTLY UNEMPLOYED	91	93

^ Many values will not reflect proportions in the general homeless population due to deliberate oversampling of some groups in some sites

Table 2. Homelessness History — Moncton and National Samples

	MONCTON TOTAL SAMPLE N =201 %	NATIONAL TOTAL SAMPLE N =2148 %
HOMELESS STATUS AT ENROLMENT		
Absolutely homeless*	56	82
Precariously housed	44	18
FIRST TIME HOMELESS		
The year prior to the study	19	23
2008 or earlier	81	77
LONGEST PERIOD OF HOMELESSNESS IN MONTHS (lowest and highest rounded to next month)	20 (0-460)	31 (0-384)
TOTAL TIME HOMELESS IN LIFETIME IN MONTHS (lowest and highest rounded to next month)	49 (0-460)	58 (0-720)
AGE FIRST HOMELESS (lowest and highest rounded to next month)	30 (6-65)	31 (1-70)

* See Appendix A for definitions of absolutely homeless and precariously housed

Differences from the National Sample Characteristics

When compared with participants from all five demonstration sites, the Moncton sample has many similarities along with some notable differences from the national sample. Moncton's participants were similar with respect to gender, age, and the proportion with high needs.

However, a lower percentage of participants who were absolutely homeless at entry in the study was noted for Moncton (56 per cent vs. 82 per cent nationally). Likewise, Moncton had a much lower percentage of Aboriginal and ethnoracial participants than is noted at the national level. Specifically, less than 10 per cent of Moncton participants identified as either Aboriginal or of another ethnocultural background (compared to 22 per cent Aboriginal and 24 per cent ethnocultural nationally). Note that higher proportions of ethnocultural groups were recruited by study design in Toronto and Winnipeg, whereas recruitment was not targeted to particular subgroups in Moncton.

Although unemployment rates were similar between the national sample and the Moncton arm, Moncton had a lower percentage of participants with a prior month income of less than $300 (15 per cent, compared to 26 per cent at the national level) and Moncton participants had been homeless for a shorter average total time in the past.

Characteristics of the Rural Group

The rural arm included participants who were either living in Special Care Homes, living with their families, precariously housed, or homeless upon entry to the study. Twenty-four participants received Housing First and ACT services within rural communities in the southeastern region of New Brunswick and were later

matched with 19 participants who continued to receive services as usual. The rural sample was followed for a period of 18 months. The rural study sample was predominantly male (72 per cent) and francophone (79 per cent), with a mean age of 38 years.

Given the nature of this sub-sample, it is difficult to compare these participants to those in the Moncton arm, or more generally to the national sample, in many respects. Most participants had never experienced homelessness as defined in the present study. Similar to the Moncton sample, 60 per cent did not complete high school. However, 67 per cent were unemployed at the beginning of the study, which is significantly lower than what is noted in the Moncton arm. At study entry, 30 per cent reported symptoms consistent with a psychotic disorder. Substance-related problems were substantially lower in the rural sample than in both the Moncton and national samples, with only 35 per cent reporting substance-related problems. Similarly, alcohol-related problems were reported by only 30 per cent of rural participants.

Table 3. Health, and Social Circumstances — Moncton* and National Samples

	MONCTON TOTAL SAMPLE N =201 %	NATIONAL TOTAL SAMPLE N =2148 %
Need level (determined by study screening)		
High need	36	38
Moderate need	64	62
Adverse Childhood Experiences (ACE)		
Mean score (out of a possible 10)	5.0	4.6
COGNITIVE IMPAIRMENT		
Got extra help with learning in school	49	41
Has a learning problem or disability	37	34
DIAGNOSIS AT ENROLMENT		
Psychotic disorder	23	34
Non-psychotic disorder	86	71
Substance-related problems	73	67
SUICIDE RISK AT ENROLMENT		
Moderate or high	55	36
COMMUNITY FUNCTIONING AT ENROLMENT(rated by interviewers)		
Average MCAS score	59	60
(lowest and highest scores)	(34-80)	(33-80)
HOSPITALIZED FOR A MENTAL ILLNESS (for more than six months at any time in the past five years)	4	6
HOSPITALIZED FOR A MENTAL ILLNESS (two or more times in any one year in the past five years)	33	37
SERIOUS PHYSICAL HEALTH CONDITIONS		
Asthma	31	24
Chronic bronchitis/emphysema	24	18
Hepatitis C	26	20
Hepatitis B	3	3
HIV/AIDS	1	4
Epilepsy/seizures	9	10
Heart disease	8	7
Diabetes	7	9
Cancer	2	3
TRAUMATIC BRAIN/HEAD INJURY		
Knocked unconscious one or more times	74	66
JUSTICE SYSTEM INVOLVEMENT (arrested > once, incarcerated or served probation in prior 6 months)	36	36
JUSTICE SYSTEM INVOLVEMENT TYPES		
Detained by police	24	24
Held in police cell 24 hours or less	21	22
Arrested	27	27
Court appearance	29	30
Attended a justice service program	13	11
VICTIMIZATION		
Theft or threatened theft	29	32
Threatened with physical assault	46	43
Physically assaulted	38	37
LACK OF SOCIAL SUPPORT		
Lacking a close confidante	56	51

* Reported by participants to the interviewer

CHAPTER 4
HOUSING OUTCOMES

Moncton Site

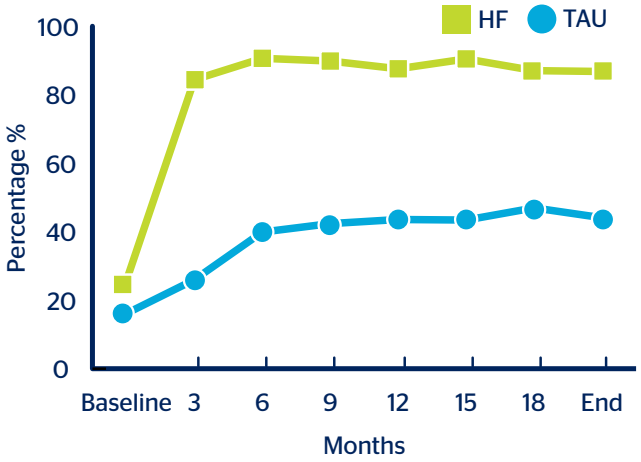


Figure 1. Percentage of Time Stably Housed[2]

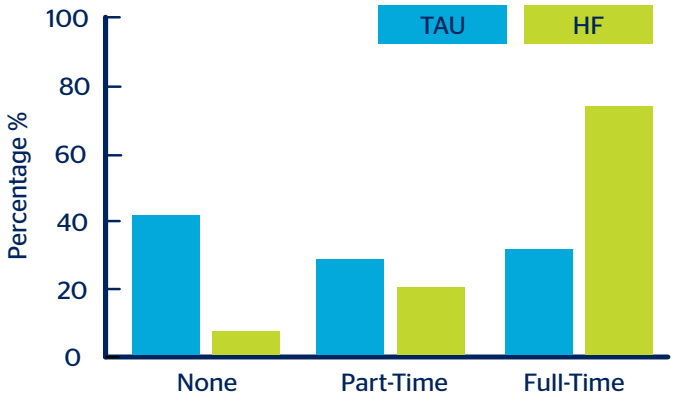


Figure 2. Housing Status in the Last Six Months (i.e., 18-24 months)[3]

Of the total number of days in stable housing, Housing First (HF) participants accounted for a significantly greater percentage relative to Treatment as Usual (TAU) participants throughout the study (see Fig. 1). The percentage of time housed for HF participants remained consistently high (i.e., > 85 per cent) for the duration of the study. For example, in the last six months of the study, HF participants were stably housed 87 per cent of the time. In contrast, TAU participants only spent 46 per cent of the last six months in stable housing.

As shown in Figure 2, almost three-quarters of the HF participants (73 per cent) were housed all of the time for the last six months of the study. In contrast, less than one-third of TAU participants (31 per cent) were housed all of the time in the last six months of the study. Moreover, only seven per cent of HF participants were not housed for any of the last six months of the study, compared to 41 per cent of TAU participants.

The average quality of housing (unit and building combined) was similar for residences of HF participants compared to residences of TAU participants. However, the quality of housing units of HF participants was more consistent (i.e., less variable) as rated by the research teams using a standard scale. That is, there were fewer HF participant units at very low levels of quality.

Rural Arm

Table 4 presents the frequency distribution of the living situation at study entry for the two groups of the rural sample. Almost two-thirds (63 per cent) of the HF participants were living either with family (42 per cent) or in a Special Care Home (21 per cent). In contrast, most of the TAU participants (90 per cent) were living in one or the other of these situations. More than one-quarter of HF participants were either precariously housed (21 per cent) or homeless (eight per cent), while none of the TAU participants were identified in either of these unstable housing situations at study entry.

For the rural arm of the project, 100 per cent of the participants in both groups were stably housed during the first three months of the study (see Fig. 3). Over the course of the 18-month study, there was no difference between the groups in terms of the percentage of time housed. Specifically, the HF participants had been stably housed 80 per cent of the time overall while the TAU group had been housed 84 per cent of the time. In the last three months of the study, HF participants were stably housed 86 per cent of the time compared to 87 per cent of the time for TAU participants.

As shown in Figure 4, 75 per cent of rural HF participants were stably housed for all of the time in the last months of the project. In

[2] HF (N = 76-97); TAU (N = 72-85)
[3] HF (N = 93); TAU (N = 75)

Table 4. Living Situation at Study Entry of the Two Groups in the Rural Sample

LIVING SITUATION AT STUDY ENTRY	HF N=24 %	TAU N=19 %
Living with family	42	42
Special Care Home	21	48
Precariously housed	21	–
Homeless	12	–
Other	4*	5**
Not known	4	5

* Living in own place with support from parents.
**Living in own place on First Nations Reserve.

comparison, 78 per cent of rural TAU participants were housed all of this time. Only four per cent of the HF participants (N = 1) and six per cent of the TAU participants (N = 1) were housed none of the time in the last six months of the study.

Overall, it is important to note that the lack of differences between the groups in terms of housing outcomes despite the differences in housing stability between the two groups at study entry. In particular, as previously noted, more than one-quarter of the HF participants recruited for the rural arm were either precariously

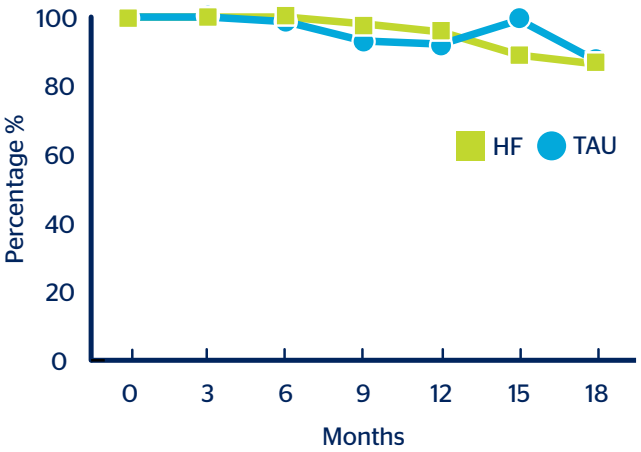


Figure 3. Percentage of Time Stably Housed – Rural Region[4]

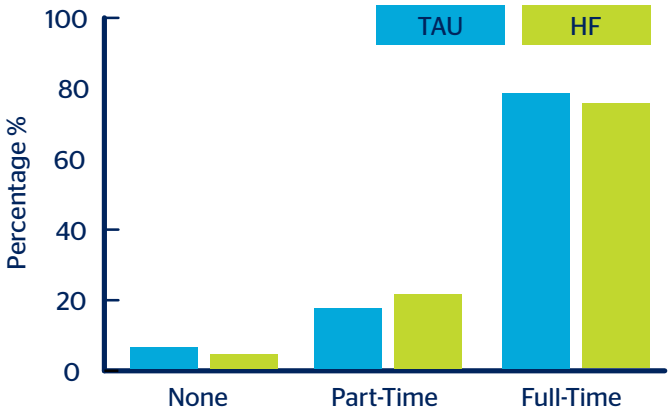


Figure 4. Housing Status in the last Six Months (i.e., 12-18 months) – Rural Region[5]

housed (i.e., recently homeless) or actually homeless, while all of the TAU participants were considered stably housed.

[4] HF (N = 19-24); TAU (N = 17-19)
[5] HF (N = 24); TAU (N = 17)

CHAPTER 5
SERVICE USE OUTCOMES

Generally, the trend in both the Housing First (HF) and the Treatment as Usual (TAU) groups for the Moncton site is similar to the national results, showing a decrease in the use of most types of health and homelessness services during the course of the study. This general trend can likely be attributed in part to a statistical phenomenon called "regression to the mean." That is, participants were referred to the study in a moment of crisis that abated for both groups as time went by. However, the use of food banks and visits from health care providers did not follow this pattern in Moncton or nationally; more of these services were used by the HF group than the TAU group. Over the previous six-month period, use of food banks was higher in the HF group at 12 (3.49 vs. 2.12 visits) and 18 months (3.50 vs. 3.00 visits), but otherwise similar to the TAU group. This is not unexpected since service visits are integral to HF services, and having a place with a kitchen enables the use of food bank services.

Some differences in service use between the HF group and the TAU group were observed in the Moncton site. Phone contacts with health care providers were more than twice as frequent in the HF group from study entry to six months (2.61 vs. 0.81 contacts per month on average per participant), and from six to 12 months (1.74 vs. 0.74 contacts), but were similar for both groups from 12 to 18 months and from 18 to 24 months. The HF and TAU groups made the same number of visits to outpatient clinics early in the study, but by the end (12 to 18 months and 18 to 24 months), there were twice as many visits by participants from the TAU group (0.70 vs. 0.37, and 0.70 vs. 0.34 visits, respectively).

Calls to crisis lines decreased for both groups over the course of the study, but the HF group showed a significant spike over the course of the 18 to 24 month period (2.64 vs. 0.16 calls), which might have been triggered by uncertainty and anxiety related to the end of the study and the potential loss of housing. Visits by crisis teams increased in the TAU group and were significantly more frequent over the course of the 12 to 18 month period (this difference was maintained from 18 to 24 months). However, given its very low frequency, this result should be interpreted cautiously.

The number of ambulance trips was similar for HF and TAU groups throughout most of the study, but spiked from 18 to 24 months for the HF group (0.41 vs. 0.23 trips), enough to be significantly higher than in the TAU group. Drop-in centre visits were more frequent in the TAU group from study entry to six months (67.42 vs. 44.07 visits) and from six to 12 months (55.43 vs. 34.86 visits), but then decreased to the same level as the HF group. This suggests that the decrease in use happened sooner in the intervention group.

Participants from the TAU group had more contact with security personnel over the first six months of the study (0.54 vs. 0.23 contacts) and from six to 12 months (0.37 vs. 0.07 contacts), but had the same level of contact as the HF group in the second year of the study. There were no differences between groups for the other variables (visits to health care provider, visits to the emergency room, number of police contacts, number of times detained without being held in a cell, number of times held in a cell, number of times arrested, number of court appearances, and number of contacts with justice programs).

Even though most of the results observed in the Moncton site follow the national trends closely, there are a few noticeable differences. For example, phone conversations with crisis lines tended to decrease in the HF group in Moncton, whereas overall, they increased in the HF arm of the national study. Also, the increase in visits by crisis teams for the TAU group in Moncton is not paralleled in the national sample. These differences are likely attributed to different types of existing services and different availability of these services across sites. The significant spike in ambulance use that occurred in the period of 18 to 24 months for the Moncton HF group also appears to be unique to Moncton. Note that this is based on self-reported use of services, which may not be accurate due to the limits of recall. The results of a similar analysis using health and justice administrative data will be completed and reported in 2014.

In the rural arm, service use was not different between the HF group and the TAU group throughout the course of the project, with the exception that the HF group was significantly more likely to use food banks at all time-points, including baseline.

CHAPTER 6
COST OUTCOMES

...every $10 invested in services resulted in an average savings of $7.75.

The Housing First (HF) intervention in Moncton cost $20,771 per person per year on average. These costs included salaries of all front-line staff and their supervisors, additional program expenses such as travel, rent, utilities, etc., and rent supplements. Over the follow-up period, by comparing the costs of services incurred by HF participants with those of Treatment as Usual (TAU) participants, the intervention resulted in average reductions of $16,089 in the cost of services. Thus, every $10 invested in services resulted in an average savings of $7.75. The main cost offsets were office visits in community health centres and with other community providers ($8,473 per person per year), hospitalizations in medical units in general hospitals ($4,220 per person per year), and stays in detox facilities ($2,731 per person per year). Other cost offsets were all less than $1,000 per person per year.

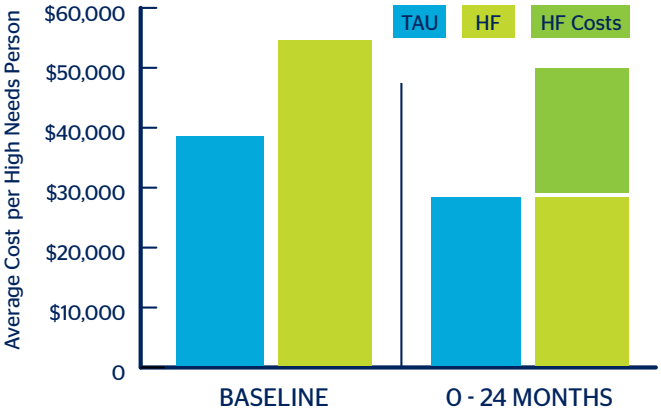


Figure 5. Baseline vs. 24 months cost offsets for HF

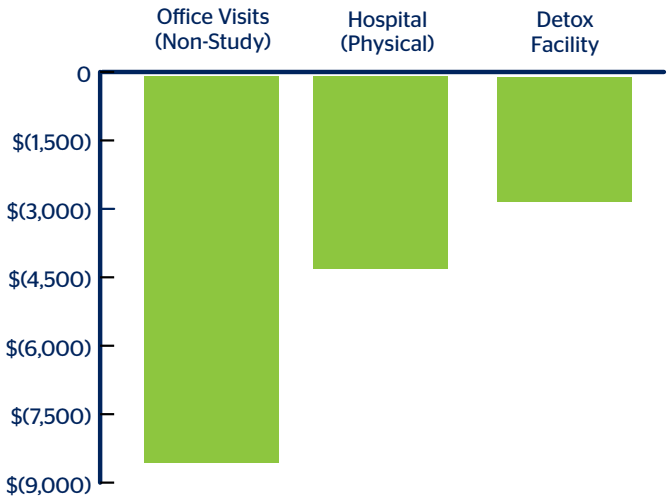


Figure 6. Cost offsets by type of service

The cost of Assertive Community Treatment (ACT) support and rent supplements totaled $1,790 per month. In the rural region, individuals with severe and persistent mental illness who are not living with their families are typically placed in privatized Special Care Homes. The average cost paid by the provincial government for placement in these residential facilities is $2,300 per month.

CHAPTER 7
SOCIAL AND HEALTH OUTCOMES

Comparison of HF vs. TAU in Moncton

Regarding overall quality of life (reported by participants), although the groups had similar baseline scores, the Housing First (HF) group reported significantly greater overall quality of life than the Treatment as Usual (TAU) group throughout the follow-up period. More specifically, participants from the HF group showed greater improvements in quality of life related to their living situation, leisure activities, finances, and sense of safety. Quality of life is defined as a person's satisfaction with their current life situation, overall and in specific areas.

Even after 24 months, the two groups were not significantly different regarding community functioning. However, both groups showed improvements in community functioning over the two year period of the study. Note that community functioning is rated by an observer, and not self-reported by the participant. It is defined as an individual's ability to adapt and live independently in the community as reflected by their mental health, social effectiveness, engagement in treatment, and adaptive behaviours. Participants are rated on a set of items related to each of these areas of community functioning.

The overall quality of life for the HF participants and TAU participants in the rural arm remained the same and stable over the 18 months of the study. As well, the two groups were assessed as having similar and high levels of community functioning at study entry and at the end of the study.

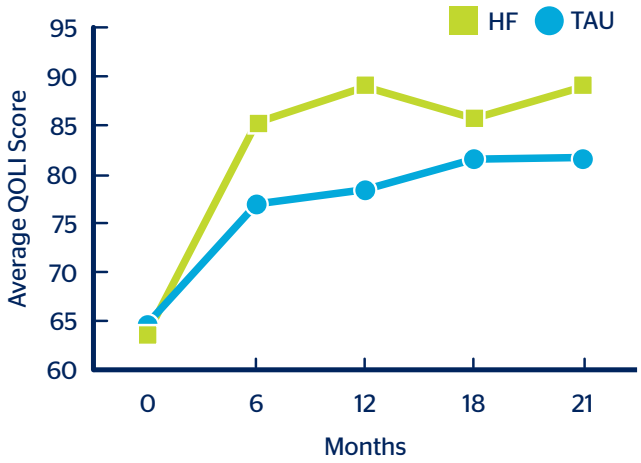


Figure 7. Quality of life from baseline to 21 months[6]

[6] HF (N = 75-97); TAU (N = 61-99)

CHAPTER 8
OTHER FINDINGS

Qualitative Findings from the Moncton Site

Qualitative interviews with a sub-sample of Housing First (HF) participants and Treatment as Usual (TAU) participants were conducted at study entry (N = 20)[7] and at 18 month follow-up (N = 16).[8] Several themes were identified in the interview transcripts that proved to be common and experienced in the same way for both HF participants and TAU participants. The first theme was related to spirituality. Spirituality played a fundamental role for participants in both groups. Some participants described how they read the Bible and others reported that they prayed in order to accept their life circumstances. Some participants noted that they believed that God had blessed them.

Another common theme emerging from the qualitative interviews was the fragility of participants' support networks. In some cases, participants described themselves as not having a support network. Only close family members, children (for those who have some), and long-term friends remained present in participants' lives, though generally in small numbers, if at all. Two self-help groups — Alcoholics Anonymous and Gambling Anonymous — were highlighted by participants in both groups as being particularly important.

Qualitative interview data analyses also identified themes that were common to both groups but were being experienced differently. The presence of pervasive feelings of insecurity was one such theme that was linked to homelessness and mental health problems. However, these feelings of insecurity for the TAU group were linked to being dependent on community services as a means of coping with them. In contrast, for the HF group of participants, feelings of insecurity were described as motivating them to regain control and autonomy in their lives.

Drug addiction was another recurring theme raised in the qualitative interviews with both groups of participants. Interview data from TAU participants described drug addictions as triggering a downward spiral that led either to prostitution to obtain drugs or social isolation as a strategy to avoid using drugs. In comparison, HF participants focused on active strategies to improve their wellbeing, including developing new relationships that facilitated decreasing or stopping the use of drugs completely.

The final theme found in the interviews of both groups related to how individuals experienced and navigated the instability associated with their mental health problems. TAU participants noted the difficulties they encountered as a result of the lack of services, the waiting lists, and hospitalizations. On the other hand, HF participants described more positive outcomes associated with their mental health problems, notably relating to the management of their medication regimens and the stability associated with having access to services.

Some other themes, notably stigmatization, the perception of psychiatry, and a lack of hope for the future, were only present in the interviews of the TAU participants. In particular, they described themselves as being poverty stricken and, as a result, living in dangerous neighbourhoods that were stigmatizing. They also viewed the negative consequences of living in inadequate housing and having to move frequently as contributing to their instability. The perception of psychiatry by TAU participants tended to be negative for the most part. They noted that the likelihood of having a good psychiatrist seemed based largely on luck and they described lacking hope about being able to improve their lives.

A number of positive themes were found to be present in the interviews of HF participants. Specifically, they described how choosing a place to live in a suitable neighbourhood made it possible to develop feelings of belonging and responsibility towards their environment. The diversity of and access to regular services were described by HF participants as making it possible for them to attain a better balance and achieve specific objectives in their lives. For example, these included such objectives as not using drugs anymore, going back to school, or making a budget. Generally, HF participants shared a perspective on the future that was more realistic than TAU participants and included both short and long-term goals.

Qualitative interviews of participants highlighted the importance of the combination of housing and support. In particular, HF participants described how the combination of receiving housing and support facilitated change and improvement in their lives in such areas as following their medication regimens, controlling their drug use, and managing their finances. They also described their future outlook as being hopeful and optimistic.

In contrast, some TAU participants who accessed NB Housing, but without consistent support, described encountering significant and ongoing difficulties related to their mental illness. Other TAU participants recounted how they received services but without stable housing, and this prevented them from moving forward or experiencing sustained improvement in their wellbeing.

[7] HF (N = 10); TAU (N = 10)
[8] HF (N = 8); TAU (N = 8)

Qualitative Findings from the Rural Arm

When examining participant narratives collected through qualitative interviews with a subsample of rural participants interviewed at study entry[9] and 18 months,[10] two groups emerged: namely participants with positive trajectories over the course of the study, and those with negative trajectories. HF participants reported more positive trajectories and described their participation in At Home/Chez Soi as giving them a life-changing opportunity. They described themselves as being supported by family members who don't stigmatize them because of their mental illness, by friends who accept them, and by a community that supports them. Most of them adhere to their medication, and any medication side effects they have are not seen as hindering their daily life.

The group reporting negative trajectories included more TAU participants than HF participants. This group described themselves as making little progress towards recovery during the study. Rejection and marginalization from family members, friends, and the community were characterized as a burden, and they held little hope of ever getting better. Some of these individuals did not acknowledge that they had mental health issues and were not seeking or participating in treatment. Consequently, they were frequently hospitalized and had few social contacts.

Overall, the narratives of rural participants revealed greater recovery in the HF group over the TAU group. Most participants in the HF group seemed to report improvement from the first to the last interview, while no change was described by the TAU group. Changes in the HF group seemed to reflect a move towards greater autonomy, increased empowerment, and a more hopeful outlook on the future.

In contrast, participants in TAU who did well early in the study were still doing well, and participants who struggled initially were still struggling at the end of the follow-up period.

In general, many of the TAU participants appeared to remain in a precarious state over the course of the study that resulted in an ongoing dependency on health and social services.

Table 5. Fidelity of Implementation – Moncton

FIDELITY DOMAINS (TOTAL POSSIBLE SCORE)	AUGUST 2010	JANUARY 2012
Housing Choice and Structure – (24)	22.5	24
Separation of Housing and Services – (28)	27	28
Service Philosophy – (40)	35	36
Service Array – (32)	20	27
Program Structure – (32)	28	28

[9] HF (N = 11); TAU (N = 11)
[10] HF (N = 11); TAU (N = 8)

Fidelity Assessments

An important component of study methods was the measurement of how "true" the programs were to the principles and practice of HF (also called fidelity). These fidelity assessments were conducted with all the At Home/Chez Soi service teams in the five sites by a team made up of clinicians, researchers, housing experts, and a consumer representative. In site visits conducted at two time points in the study, the team reviewed data from multiple sources including interviews with staff, observation of program meetings, chart reviews, and consumer focus groups. A HF fidelity scale was developed for the study and used to rate programs on 38 items, including, for example, working effectively with hospital staff for people admitted as inpatients, using a harm reduction approach to substance use, and allowing participants to help choose their housing. (A copy of the fidelity scale can be accessed in the Follow-Up Implementation and Fidelity Evaluation of the Mental Health Commission of Canada's At Home/Chez Soi Project: Cross-Site Report, available at http://www.mentalhealthcommission.ca/English/node/13611?terminitial=38)

The fidelity assessments in Moncton found that the Moncton site program (i.e., in Moncton and the rural arm) achieved very good fidelity to the HF model. Two fidelity assessments were completed in Moncton, once in August 2010 and again in January 2012. The program was functioning in alignment with Housing First recovery-oriented philosophy and practices. There was notable improvement from time one to time two on the Service Array domain, and while scores were high across domains, there was some room for improvement in the Service Philosophy, Service Array, and Program Structure domains (Table 5). (Appendices D & E present summaries of the findings of the evaluation of implementation conducted on the HF program in 2011 and 2012.)

The goal of the Peer Supportive House was to house participants immediately and prevent a return to homelessness for HF participants who experienced continued housing instability after multiple evictions from housing units in which they were placed by the HF program.

Findings of the Implementation Evaluation of the Peer Supportive House

The Moncton site implemented a Peer Supportive House, as an option to support individuals for whom stable housing was not achieved in the first year of the project. The Peer Supportive House was located within walking distance of Main Street and many frequently accessed services in the community (e.g., social services, health services). The house had six large apartments, including one that housed the peer support couple who also served as building superintendents. At the time of the evaluation of the Peer Supportive House, nine participants in the At Home/Chez Soi project had lived there.

Peer support was offered by a resident couple, both whom had lived experience with substance use, mental illness, and housing instability. Services were offered on site through direct assistance from the peer support couple and through home visits from the Assertive Community Treatment (ACT) team. As well, the house had increased security measures that would not be found in regular housing (e.g., security cameras, key card access), to limit and regulate access by visitors. It also had tenant rules (e.g., no visitors after 11 p.m., no smoking indoors, etc.).

The goal of the Peer Supportive House was to house participants immediately and prevent a return to homelessness for HF participants who experienced continued housing instability after multiple evictions from housing units in which they were placed by the HF program. In addition to housing participants with ongoing housing instability, the house was used as temporary housing for participants who were waiting for an apartment to become available to them.

An evaluation of the Peer Supportive House was conducted between January and April 2013. (See Appendix F for a summary of the evaluation findings.) Participant and key informant interviews examined understanding of the goals of the house, implementation challenges, strengths and weaknesses of the approach, perceived early impacts, and suggestions for improvement. Nine participants were interviewed as well as five key informants (i.e., the Physician Clinical Director of the ACT team, Housing Lead of the HF program, one of the peer superintendents of the apartment block, and two ACT team members).

Overall, the goals and purpose of the house were well understood. However, some participants and staff had different understandings about the expected duration of stay at the house, with some expecting that it was a permanent option and others seeing it as a transitional placement. Challenges with implementation included a variety of communication issues, and a poor fit between the needs of the emergency/transitional participants and the added structure, rules, and supports offered by the peer superintendents.

Other challenges related to the purchase of the building, location, and general challenges experienced by staff in working with this group of participants. At the time of the interviews, most challenges had been appropriately addressed. Several strengths of the model were noted including the convenient location, added security, benefits of the support offered onsite, and the ability of the peer superintendents to form trusting relationships with the participants.

Weaknesses included the poor fit for those requiring only temporary housing until a housing unit in the community was available for them; some participants did not like the basement apartments, and some were bothered by the proximity of the house to a neighbourhood perceived to be dangerous. Early impacts were noted, and were positive. The house facilitated stabilization for some as illustrated by this participant's comment:

> *"Like I said, I'm on track, every morning I get up, uh, I feel great sometimes, and uh, you have, it's all like, all the rules of the place, help me stabilize my life."*

Tenants of the Peer Supportive House and key informants felt that this stabilization allowed participants to develop greater independence, to take on meaningful responsibilities, and to begin to work on their relationships with others. Suggestions for improvement included having more units available, separating participants based on their needs, and enhancing the sense of community in the building.

The Peer Supportive House, as it was piloted in Moncton, provides one option for supporting individuals with additional needs, who do not find stability in the HF model, and are likely to continue to experience chronic homelessness.

Findings from Interviews with Community Partners in Moncton and the Rural Region

Community partners (n = 13) were interviewed about their experience with and perspective on the At Home/Chez Soi project. Partners included personnel from health and social service organizations, managers of emergency shelters, and personnel from drop-in centres and food banks. Most community partners had extensive contact with the program, as it served many of their clientele. Community partners described efforts to ensure that services were not duplicated between their organization and the HF intervention, and also noted that HF had allowed them to discharge some of their participants, making room to serve others.

"I mean it is definitely a team of people who have this program at heart, and really care about these people and respect these people, and there is a level of respect for these people in wanting to help them in a respectful way and based on what they identify as their needs and stuff."

"In the 50s, the average hospitalization for mental health was seven years, in the 70s it was one year and a half. Now we are down to an average hospitalization of two weeks. We have pushed reduced hospitalizations and deinstitutionalization in hopes that the community services would better fit the needs of this population. Unfortunately there were not enough services and some clients were not ready to be on their own in the community. This is why this program is a perfect fit for this community and population."

Generally, community partners had a positive impression of the program, both in terms of the services offered, and of the quality of the services and service providers.

> *"I mean it is definitely a team of people who have this program at heart, and really care about these people and respect these people, and there is a level of respect for these people in wanting to help them in a respectful way and based on what they identify as their needs and stuff."*

Community partners commented frequently that, in their view, the combination of housing and flexible supports was the key to participants' success in HF.

Suggested improvements to the program were related to expanding the program and making it more accessible to a greater number of participants, having a lower staff to participant ratio on the ACT team, and improving communication with community organizations so that services could be offered in an even more cooperative manner. Community partners noted positive impacts for participants, including stabilization, access to mental health services, empowerment, and the opportunity to take an active role in their own recovery process. Positive impacts were also noted at the system level, including shortening waitlists for other services, and a perception that not as many people were requiring services after the implementation of HF:

> *"There are still lots of mentally ill people who access our services, but I would say there is not as many as there were before."*

Another key observation noted by the community partners was that the At Home/Chez Soi project had increased awareness and created an open discussion about homelessness, within the community as well as with municipal, provincial, and federal governments. They also noted that the project helped to bring the hidden homeless population into the open, and that it had brought about a paradigm shift in many who had been skeptical about a Housing First approach for this population:

> *"With a person with a history of schizophrenia, you think this person is incapable of recovery. But the program demonstrated that all individuals are capable of recovery; even those with severe mental illness can be successful."* (Translated)

HF was seen as a good fit with existing mental health services, and was noted to have filled a gap created by deinstitutionalization:

> *"In the 50s, the average hospitalization for mental health was seven years, in the 70s it was one year and a half. Now we are down to an average hospitalization of two weeks. We have pushed reduced hospitalizations and deinstitutionalization in hopes that the community services would better fit the needs of this population. Unfortunately there were not enough services and some clients were not ready to be on their own in the community. This is why this program is a perfect fit for this community and population."* (Translated)

CHAPTER 9
DISCUSSION AND IMPLICATIONS FOR PRACTICE AND POLICY

The combination of study outcomes over a relatively short period of time in the areas of housing and quality of life suggest that HF can begin the process of integrating persons with serious mental health issues and a history of homelessness into the community.

The findings from the Moncton site demonstrate the feasibility and value of implementing Housing First (HF) in a small Canadian city and in a rural region. The combination of study outcomes over a relatively short period of time in the areas of housing and quality of life suggest that HF can begin the process of integrating persons with serious mental health issues and a history of homelessness into the community. Seven key implications for practice and policy are noted:

1. **Rent supplements should be provided along with support services.** The superior housing outcomes for HF participants relative to Treatment as Usual (TAU) participants in Moncton over the two-year period of the study demonstrate the critical importance of providing a rent supplement along with services to individuals with serious mental illness and a history of homelessness.

2. **The needs of the rural homeless can be met by HF.** The positive housing outcomes achieved in the rural arm of this study for individuals with serious mental illness leaving Special Care Homes, family, or unstable housing situations shows that HF services can be used to transition this population successfully into their own homes in the community.

3. **The cost of HF is largely offset by savings.** Cost-related findings from the Moncton site also show that investments in HF are offset by significant savings in health, social, and justice services such that only a small outlay of supplementary net resources are required to implement HF in a small Canadian city. Ultimately, the implementation of HF in a small city frees up limited health care, social services, and justice services for other individuals waiting to access them. Also, costs associated with HF are less than the costs outlayed for individuals to live in Special Care Homes in either Moncton or southeast New Brunswick.

4. **The decreased service use of HF participants may lead to significant additional cost savings over time.** With regards to service use, the cost savings demonstrated in this two-year project may only be the tip of the iceberg. Differential service use, for example, visits to outpatient clinics and visits by crisis teams, were significantly less frequent among the HF group, but not until the 18-month follow-up point. It is possible that continued follow-up of service use over a longer period may reveal a continued advantage for the HF participants, resulting in increased recovery of costs over time.

5. **Peer supportive housing may be an effective back up strategy for those who do not stabilize in HF.** The evaluation of the Peer Supportive House that was piloted in Moncton suggests that for the small group who do not find stability in the HF model, this type of peer-based supportive intervention may provide the additional structure and support that they need to find stability. This supports the implementation of HF as a first-line strategy and the implementation of a peer supportive housing model as a backup strategy for those who do not stabilize in HF. Implementing HF and peer supportive housing in a sequential manner prevents two potential situations of poor fit: first, it prevents placing individuals who can manage more independently into a supportive housing environment that they do not need. Second, it prevents those who do not find stability in HF from falling through the cracks and experiencing chronic homelessness.

6 **Community partners see HF as a valuable addition to the service system.** Community partners to the HF program in Moncton reported having very positive impressions of the program and noted that it was a good addition to have HF in the service system. They also indicated having been able to develop a good collaborative relationship with the program over the life of the project. The combination of the outcome findings and perceptions of community partners indicate the value-added nature of having HF services as part of the mental health and homelessness service system.

7 **Stable housing facilitates positive developments in other life domains.** In addition to the positive housing outcomes experienced by HF participants, HF was found to produce quality of life benefits above and beyond those receiving services as usual. As well, both HF and TAU participants were assessed as showing improvements in community functioning over the course of the study. These findings suggest that the achievement of housing stability by HF participants is the foundation on which other positive outcomes can be produced. The planned four-year follow-up of participants in the study will allow for an assessment of longer-term value-added health and social outcomes in addition to determining the sustainability of the superior housing outcomes of HF participants relative to TAU participants.

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APPENDIX A
KEY DEFINITIONS

Eligibility

Inclusion criteria:

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

Exclusion criteria:

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

Need Level

High need

MUST HAVE:

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

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

Moderate need

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

*Absolutely Homeless / Precariously Housed

Absolute homelessness

Homelessness refers to those who lack a regular, fixed, physical shelter. This (conservative) definition is known as absolute homelessness, according to the United Nations, and includes those who are living rough in a public or private place not ordinarily used as regular sleeping accommodation for a human being (e.g., outside, on the streets, in parks or on the beach, in doorways, in parked vehicles, squats, or parking garages), as well as those whose primary night-time residence is supervised public or private emergency accommodation (e.g., shelter, hostel).[iii] Specifically, being homeless is defined as currently having no fixed place to stay for more than seven nights and little likelihood of obtaining accommodation in the upcoming month[iv] or being discharged from an institution, prison, jail, or hospital with no fixed address.

Precariously housed

This refers to people whose primary residence is a Single Room Occupancy (SRO), rooming house or hotel/motel. In addition, precariously housed individuals in the past year have had two or more episodes of being absolutely homeless, as defined above, in order to meet the criteria for inclusion.

Relatively homeless

This includes people whose regular housing fails to meet basic standards, such as: (1) living in overcrowded or hazardous conditions; (2) those at risk of homelessness, such as people who reside informally/non-permanently with friends or relatives (e.g., doubling-up, couch surfing); (3) those in transition (e.g., women, youth fleeing to transition houses/shelters from domestic abuse); (4) those who are temporarily without a dwelling (e.g., home lost for a relatively short period of time due to disasters such as a fire, or a change in economic or personal situation, such as marital separation or job loss; and, (5) those living in long-term institutions.

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

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

^Serious mental disorders

Serious mental disorders are defined by diagnosis, duration, and disability using observations from referring sources, indicators of functional impairment, history of recent psychiatric treatment and current presence of eligible diagnosis as identified by the Mini International Neuropsychiatric Interview (major depressive, manic or hypomanic episode, post-traumatic stress disorder, mood disorder with psychotic features, psychotic disorder).

REFERENCES FOR APPENDIX A

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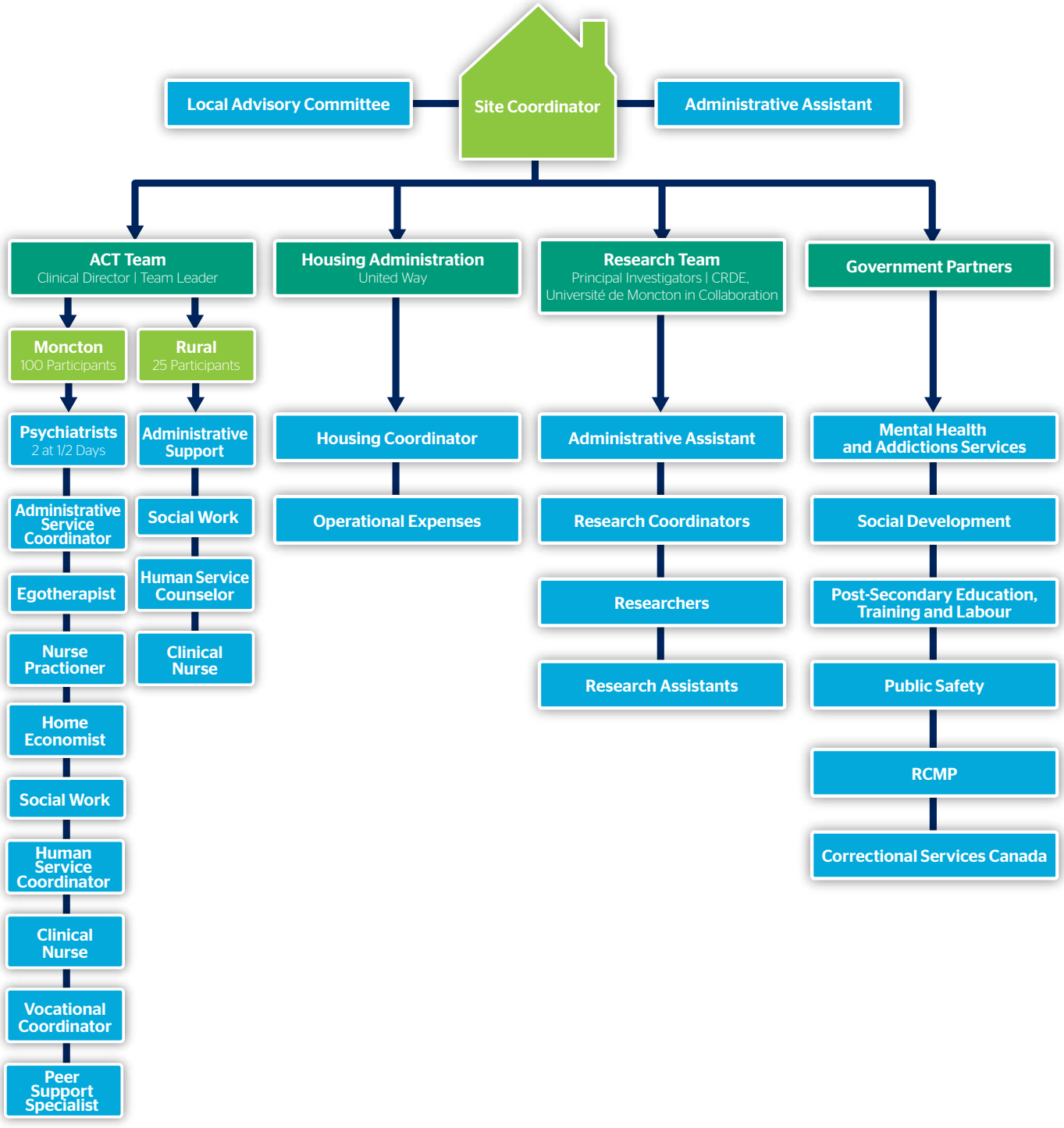
APPENDIX B

ORGANIZATIONAL CHART FOR THE MONCTON SITE AT HOME/CHEZ SOI DEMONSTRATION PROJECT



APPENDIX C
OVERVIEW OF STUDY DESIGN AND METHODS

Study Design

The At Home/Chez Soi study design is a **randomized controlled pragmatic field trial**.[1] *Randomized* means that participants were put into the Housing First (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 — with four larger urban settings and one smaller urban/rural setting so that more could be learned about how HF programs fit or can be adapted to local contexts.

Why a Randomized Controlled Trial?

Although there were a range of options for study designs, a randomized controlled trial was chosen because it is the best design for showing that participant changes are due to the intervention. This is because randomizing makes the two groups virtually equal on anything other than the intervention that could produce the outcomes. As such, a randomized controlled trial provides the strongest evidence for decision making.

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

Data collection included interviews with participants at baseline and every three months for up to two years of follow-up, plus information from the programs (such as the number of service visits), and from national and provincial administrative data sources for health and justice service use before and after the beginning of the study. The first participant in Moncton was enrolled in October 2009 and the last interview ended in February 2013. All participants were screened need groups (see Appendix A for definitions) before being randomized to HF and TAU groups. Participants were given honoraria ($20 – 30) at each interview to encourage continued participation. Data were entered using laptops in the field to a highly secure national database approved by Research Ethics Boards at all sites. Data collection included both quantitative (information based on numbers) and qualitative (information based on text and stories) approaches. Qualitative methods complement the quantitative findings and enhance their interpretation. For the qualitative component, a sample of participants were interviewed in depth at the beginning of the study and at the 18-month point.

What Type of Information was Collected?

A comprehensive range of information was collected in the study at all sites including demographic information (such as age, sex, and education), homelessness and service use history (e.g., emergency room visits, hospital admissions, jail stays, court appearances), adverse childhood experiences, mental and physical health status (including chronic illnesses and history of brain injury), work and income-related information, and extensive service cost information. The study is also the first to include a measure of Recovery and an observer-rated housing quality measure, to document in detail the role of peer support and fidelity to the program model, respectively (see Appendix C).

The primary outcomes measured at all sites were **housing stability**, **community functioning**, and **quality of life**. These three variables are described in greater detail below. Interested readers are referred to the study protocol at the first reference below for greater detail on the full range of measures, and to the site reports for more information on additional site-specific data.

Housing (RTLFB)

Information on the types and locations of stays (including any type of shelter or crisis housing, temporary or longer-term residences, and street locations) for every day during the study period were collected every three months using the Residential Time-Line Follow-Back (RTLFB) instrument.[2] This involves the use of a calendar to systematically guide the participant in recalling all the locations and types of housing that he or she has resided in during the prior period. The RTLFB was developed for and has been validated in HF programs and clients. It was modified slightly to reflect the Canadian context.

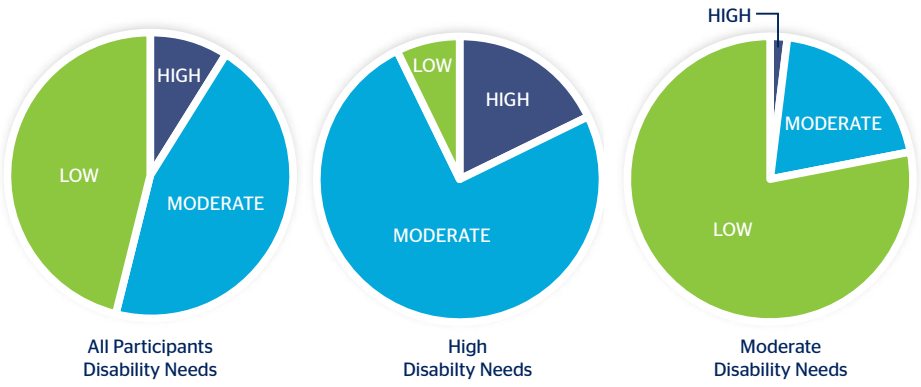


Table A2 – Categories of Disability on the MCAS and Percentages Overall and by Study Need Level

DISABLITY LEVEL	ALL	HN	MN
High (Score less than 47)	9%	18%	2%
Moderate (Score of 48-62)	45%	75%	20%
Low (Score of 63-85)	46%	7%	78%

Community Functioning (MCAS)

To assess community functioning, we used the Multnomah Community Ability Scale (MCAS),[3] a 17-item scale that covers mental and physical health, ability to cope with illness, social skills, and problem behaviours. The MCAS was developed and validated for individuals with long-term mental health issues and related disability. It produces a total score that has total scores ranging from 17 to 85. Score ranges that represent specific categories of functioning/disability and the proportions of our study participants who fell into each are outlined in Table A2.

While the other main instruments consist of questions answered by participants, the MCAS is completed by the interviewer, based on information collected through interviews, observed behaviour, and current life circumstances. This approach was taken to ensure that outcomes reflected both participants' perspectives and objective ratings by study research staff.

Quality of Life

We measured participants' feelings about their quality of life with the Quality of Life Index (QOLI-20),[4] which asks about satisfaction with family relationships, social relationships, finances, leisure, living situation, and safety. This instrument was developed and validated with individuals with long-term mental health issues.

Analysis Methods for Primary Outcomes

The following analytic methods were used for the purposes of this report for housing stability, quality of life and community functioning.

To analyze housing stability, quality of life, and community functioning outcomes, we used mixed effects modeling. Mixed effects models make it possible to measure the associations between outcomes and predictor variables while taking into account the non-independence of observations. (In this case, non-independence is present because there are multiple interviews for each participant. Less importantly, participants were also grouped into treatment arms and cities.)

In each model, the main predictor of interest was group membership: whether a participant had been randomized to HF or TAU. In national-level models, we also controlled statistically for age, sex and the variables that played a role in determining the group assignment: city, aboriginal status, ethnoracial status, and need level. We treated time as a categorical variable, essentially estimating group differences and treatment effects at every time point. To test group differences, we interacted the time and group variables, which produces estimates of group differences at each time point.

To measure the overall effect of the intervention, we considered: (1) the group difference at the end of the study (after taking any baseline differences into account); and (2) the average difference across all interviews conducted after baseline. The first measure reflects the treatment effect at the last time point available for each person. The second reflects the overall benefit, if any, realized over the entire course of the two-year study. Because we performed an interim analysis with a p value of 0.01, we set the significance threshold at 0.04 in the final report.

Analysis Methods for Costing

The economic analyses were conducted from the point of view of society. Service use and residential questionnaires enabled us to assess quantities of a wide range of services used, as well as of income from various sources. We estimated unit costs (e.g., the average cost of an emergency room visit, of a police arrest, of a night in a shelter) city-by-city using the best available data. Nearly 400 distinct unit costs were estimated. In many cases, service providers were contacted to obtain their financial and activity reports and to help interpret them. When a program's expenditures included contributions by private donors as well as government sources, we included the value of private contributions as this represents the full cost of service delivery from the point of view of society. Welfare and disability payments were included as they represent costs that society must incur in order to enable individuals who are homeless to participate in and benefit from HF programs and other existing housing programs.[7] Income from employment was subtracted from overall costs as this represents the value of a contribution to society by the individual. Estimates of capital costs were included in all services. All costs were expressed in fiscal year 2010–2011 Canadian dollars. Due to the two-year follow-up period, we did not apply discounting.

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APPENDIX D
SUMMARY OF FINDINGS OF FIRST IMPLEMENTATION EVALUATION

The appendix provides a summary of the findings of the first evaluation of implementation of the Housing First (HF) program at the At Home/Chez Soi Moncton site conducted between October 2010 and March 2011. Data was collected for the evaluation from the different groups of stakeholders of the program, namely consumers (N = 14), landlords (N = 11), service staff (N = 11), and key informants comprised of housing staff, program managers, consulting psychiatrists, co-lead investigator, and site coordinator.

What is Working Well in Implementation?

- Overall, the findings of the current evaluation highlight the successful implementation of the At Home/ Chez Soi program in Moncton and southeastern New Brunswick. There was consensus among the program stakeholders that the key components expected of a HF program modeled on the Pathways to Housing program were in place.
- The development of a growing pool of landlords who, in large part, expressed commitment to the program and its participants is evidently a critical ingredient to helping participants establish stable permanent housing. This commitment of landlords appears to be present even in the face of challenges encountered in housing some of the program participants.
- There was also consensus among the different groups we interviewed that the program is delivering timely and effective multidisciplinary support to participants. A notable strength of the program is the establishment of strong partnerships with government departments and community agencies in the not-for-profit sector.

What is Not Working Well in Implementation?

- Despite this early implementation success, there is a realization by program stakeholders that program capacity needs to be developed in a number of areas, namely addictions treatment, vocational and educational support, peer support, education related to food preparation and nutrition, and psychiatric consultation.
- Consumers in the program, who had established housing stability, expressed an interest in finding productive and meaningful ways to use their time. In order for the program to respond to these important emerging needs, it will require moving services from being less reactive in nature to being proactive and recovery-focused.
- Key informants, staff, and consumers raised the significant workload of staff as a concern. The combination of undertaking a new professional role and the team taking on a full case load in a protracted period of time has contributed to this heavy workload.
- Key informants and staff highlighted the importance of consumers having access to transportation. Despite the significant efforts taken by program staff to accommodate consumers with rides, it was still perceived by staff that they were not able to meet all of consumers' needs in this area.
- Although the program has been successful in developing a relatively large pool of landlords (i.e., currently more than 30) committed to the program, managing the relationship between landlords and the program and landlords and program participants is an ongoing challenge.
- In addition to the importance of keeping the lines of communication open with landlords, staff reported a need for better communication with both the legal and the health care systems.

Cross-cutting Themes/Issues

1. The program theory behind the At Home/Chez Soi program in Moncton described by program stakeholders in this evaluation corresponds well to the Pathways model as presented in the literature and in the training provided by Pathways staff for this project. Perceived core ingredients of the program in Moncton included facilitating access to affordable housing, offering choice in housing and support, providing consumer-centred support, and adopting a recovery orientation in establishing goals and working with consumers.
2. The success of implementing a supported housing approach, such as the At Home/Chez Soi program, rests heavily on the quality of relationships among program staff, between program staff and consumers, and between the program and landlords. The psychosocial interventions delivered in supported housing require strong working alliances among all of the program stakeholders for them to be effective.
3. The delivery of services and supports to consumers in the context of the At Home/Chez Soi program has proven to be challenging and demanding work for program staff. It requires flexibility, openness, and a willingness and comfort with extending beyond traditional roles for which staff are trained within their professional disciplines. The complex needs of consumers in the At Home/Chez Soi program can also place heavy demands on program staff especially in the initial stages of participation in the program.
4. The evaluation findings highlight the important role that community partnerships have played in the successful implementation of the At Home/Chez Soi program. From the outset, the program has been able to develop strong and supportive partnerships in the community. The creation of committees for participation by community partners are important structures contributing to the success of these collaborations.
5. Consumers receiving services from the program appear to be an untapped resource who could make important contributions to the supports being delivered by the program.
6. The relatively small size of Moncton and the addition of a rural arm make the study at the Moncton site unique and distinct from previous research on HF and from other sites in the At Home/Chez Soi project. A notable advantage is that the smaller size of the community makes it easier to integrate new and innovative services. A disadvantage is the relative ease with which information can circulate among landlords about consumers and among consumers about the services they receive from the program.

Lessons Learned

1. There is recognition among key informants and program staff of the importance of further program development to achieve longer-term anticipated outcomes of the program. In particular, key informants and program staff highlighted the need for extending program capacity so that more targeted interventions can be delivered to consumers in the areas of addictions treatment and vocational/educational support. The expertise available from the Mental Health Commission of Canada, Pathways, other At Home/Chez Soi sites, and resources available from Substance Abuse and Mental Health Services Administration (SAMHSA) can assist the program to develop capacity in these areas.
2. As previously described, the program has successfully built very good relationships among program stakeholders that include program staff, consumers, research staff, landlords, and community agencies. Ensuring that the relationships continue to be positive will be an ongoing challenge for the program. The continued planning of events, which have contributed significantly to effective relationship building, is recommended.
3. The Mental Health Commission of Canada has invested significantly since the beginning of At Home/Chez Soi in the training of program staff. The program has been fortunate to have personnel from Pathways involved in the training and providing technical support. This training and support have been particularly vital for the Moncton staff because the services, including the Assertive Community Treatment (ACT) model, have not been provided previously in New Brunswick. It will remain important that training and the receipt of technical support continue to be a priority.
4. The At Home/Chez Soi program has developed strong collaborations with relevant ministries in the provincial government and with community agencies from the not-for-profit sector in Moncton. The creation of a Local Advisory Committee, Regional Directors' Committee, and Non-Profit Sector Committee appears to have played an important role in developing these collaborations. It will be important to continue to solicit the input of partners for further program development through these committees.
5. A fundamental value of the Housing First philosophy of Pathways is the empowerment of consumers. As presented in this report, consumers provided a fresh and distinct perspective on the program that included several suggestions for improving services. Therefore, it is recommended that the program develop a systematic process for obtaining consumer feedback and input for program improvement purposes. In addition, it is recommended that the program develop a peer self-help group as another means of empowering them.
6. There is recognition by everyone involved in the program of the importance of landlords to its long-term viability since establishing stable housing is a foundation for the delivered support. The rapid and effective response of the program, in most instances, when informed by landlords of concerns about tenants, has been crucial to keeping them supportive of the program. It is critical that this timely and effective troubleshooting continue to be part of the support provided to consumers. As well, it is recommended that the program continue to make efforts to educate and inform landlords about the program by continuing to hold periodic meetings with them.

APPENDIX E
SUMMARY OF FINDINGS OF SECOND IMPLEMENTATION EVALUATION

The appendix provides a summary of the findings of the second evaluation of implementation of the Housing First (HF) program at the At Home/Chez Soi Moncton site conducted between February and July 2012. Data for the evaluation was collected from different stakeholders of the program, namely landlords (N = 12), service staff (N = 8), and key informants comprised of housing staff, program managers, and the site coordinator.

Overall, the findings of the second implementation evaluation highlight the continued successful implementation in large part of the At Home/Chez Soi program in Moncton and southeastern New Brunswick. There was consensus among the members of the team conducting the second fidelity assessment, program managers, and staff that the key ingredients expected of a Housing First program modeled on the Pathways to Housing program were present in the program. In particular, the majority of program managers and staff viewed the process as implementing a program that assisted a large majority of its participants to establish stable housing and begin the process of recovery and community integration.

The second fidelity assessment indicated that the program in Moncton had effectively addressed a number of issues raised in the first fidelity assessment. However, the second fidelity assessment also identified the presence of a number of challenges that continued to be faced by the program. Notable program areas requiring further development included the integration of disordered substance use treatment into services delivered by the Assertive Community Treatment (ACT) team, the use of individualized service planning focusing on recovery goals, and the addition of a peer specialist to the ACT team.

Cross-cutting Themes/Issues

1. Overall, the second fidelity assessment conducted in January 2012 confirmed that the At Home/Chez Soi program is continuing to implement a HF approach modeled on the Pathways to Housing approach at a high level of fidelity. As well, the results of the second fidelity assessment reflect program development in the direction of improved fidelity in a number of areas, particularly as it relates to the breadth of services offered to participants by the program. In general, the findings emerging from the second fidelity assessment corresponded with the perceptions of the program shared by key informants and program staff.
2. Despite this high level of program fidelity and successful program development and improvement, the second fidelity assessment identified a number of areas in which the program could be improved. Noteworthy program areas requiring further development included the integration of disordered substance use treatment into the services offered by the ACT team, goal planning with participants that would direct services to be more recovery-focused, and the addition of a trained peer specialist as a member of the ACT team.
3. According to key informants and program staff, a large number of program participants are experiencing, many for the first time, a sense of stability in their lives. This stability has been the result of their acquisition of secure and comfortable housing, improvement in functioning, and support from the program. As a result of this stability, participants are achieving vocational goals, engaging in program activities, and developing new social relationships. Challenges do remain for some participants, particularly those with substance use issues and those having difficulty adjusting to their new housing situations.
4. Overall, a majority of interviewed landlords perceived the program positively despite having encountered difficulties with some participants as tenants. Some landlords viewed the program as being very supportive in response to concerns or problems they encountered with participants as tenants. Other landlords reported a lack of responsiveness from the program when they reported problems encountered with program participants.
5. Program sustainability has created feelings of anxiety and uncertainty amongst participants and staff. Although participants have been informed that the ACT team will be sustained, the major concern is the continuation of housing subsidies. The program staff have been respectful of participants' concerns around housing and are being transparent in communicating information about program sustainability. Although uncertainty exists, the Site Coordinator and staff have undertaken significant efforts to address the sustainability issues related to housing subsidies for program participants.

Lessons Learned

The following lessons learned refer to recommended actions intended to address the issues described in the previous section:

1. The second fidelity assessment, key informant interviews, and focus groups with program staff, highlighted the continued need for the program to further develop program capacity in the area of addictions treatment. As suggested in the previous implementation report, it is recommended that the program work on implementing "integrated treatment strategies," an evidence-based approach that combines mental health and disordered substance use services in one setting (SAMSHA, 2010a). As well, it is recommended that training on motivational interviewing continue to be offered with staff and include supervision follow-up to this training that can assist staff to develop their skills in this area in working with participants.
2. Although the program was assessed as having improved its implementation of person-centred planning in the second fidelity assessment, it remains an underdeveloped service area. It is recommended that a service planning process should be taken to systematize the service planning process with participants so that it's feasible, individualized, and integrated into the services delivered to program participants. To assist the program to implement these recommendations, it may prove worthwhile for program staff to receive training and follow-up consultation on person-centered planning. As noted in the second fidelity assessment results, the service providers on the rural team can be an important resource within the program from which to draw to address this issue.
3. The second fidelity assessment also identified the lack of a peer specialist position on the ACT team as an ongoing implementation deficit for the Moncton program. However, as described by the key informants and program staff, the program has made important progress towards addressing this issue by identifying five potential peer specialists and providing them with training. It is recommended that the program now work towards integrating these trained peer specialists into the ACT team.
4. The second fidelity assessment highlighted the progress made by the program in the provision of vocational/educational support by having a vocational specialist as a member of the ACT team. As suggested in the first implementation report, it is recommended that the vocational specialist continue in the direction of implementing "individual placement and support (IPS) or supported employment" that includes supporting program participants to work in the regular job market. As noted in the first implementation report, the Montréal site of At Home/Chez Soi is implementing IPS and it can continue to serve as a useful consultation resource for the vocational specialist on the Moncton team.
5. The addition of one half day of psychiatric consultation was assessed as a program improvement in the second fidelity assessment. At the same time, they indicated that the amount of psychiatric consultation was insufficient relative to the needs of participants. As well, one of the psychiatrists was only available to see participants at the hospital where she worked. Moreover, the amount of available consultation time by psychiatrists precluded them being able to do home visits. Therefore, it recommended that the program work towards increasing the amount of psychiatric consultation available to the program.
6. As described in the second fidelity assessment report, the acquisition of a "transitional" apartment building has served as a way to engage and work more closely with participants who have experienced multiple evictions and difficulty living independently in their own place. In line with the direction suggested in the fidelity report, it is recommended that the program work with these individuals with the goal of assisting them to return to independent housing. It is also noted that it is possible that some of individuals in transitional housing will choose to live there on a more permanent basis. As well, it is recommended that a formative evaluation be conducted that focuses on reviewing best practices regarding transitional housing in the mental health field, identifying the needs of the participants living in the program's transitional housing, and evaluating the extent to which transitional housing is responding to these needs.
7. Interviews with landlords suggest that the program has cultivated positive and committed relationships with a large proportion of them who are renting to program participants. At the same time, similar to the findings of the first implementation evaluation, landlord interviews identified a number of challenges that they had encountered. These challenges have included a lack of information about the program, difficulty contacting the program when encountering problems, and a perception that some participants are not receiving sufficient support. Given these challenges communicated by the landlords, it is recommended that the program continue to make efforts to educate and inform landlords about the program by continuing to hold regular meetings with them. These meetings can serve to provide information about program participants, harm reduction, recovery principles, and the Housing First approach. The model developed by Kloos, Zimmerman, Scrimenti, and Crusto (2002) for working with landlords and property managers can serve as a useful guide for this work. As well, it is recommended that the program develop a brief, common-language information pamphlet on the program for landlords that includes contact numbers of program staff that landlord can contact if necessary.

APPENDIX F
SUMMARY OF THE EVALUATION OF THE PEER SUPPORTIVE HOUSE

The goal of the Peer Supportive House was to house participants immediately and prevent a return to homelessness for Housing First (HF) participants who experienced continued housing instability after multiple evictions from housing units in which they were placed by the HF program. In addition to housing participants with ongoing housing instability, the house was used as temporary housing for participants who were waiting for an apartment to become available to them.

An evaluation of the Peer Supportive House was conducted between January and April 2013. Participant and key informant interviews examined understanding of the goals of the house, implementation challenges, strengths and weaknesses of the approach, perceived early impacts, and suggestions for improvement. Nine participants were interviewed as well as five key informants (i.e., the Physician Clinical Director of the Assertive Community Treatment [ACT] team, Housing Lead of the HF program, one of the peer superintendents of the apartment block, and two ACT team members).

The evaluation demonstrated that there is significant support for the Peer Supportive House in Moncton. Both clients and key informants perceived that the housing and services offered at the Peer Supportive House are producing positive outcomes for its tenants. This early study on the Peer Supportive House demonstrates how it can be integrated into a HF program. One of the goals of HF is to ensure that no client is left behind. Typically, HF programs support individuals to live in independent housing. However, research has shown that there is a group of approximately 15-20 per cent of clients who continue to experience housing instability (Tsemberis, 1999; Tsemberis et al., 2000; Tsemberis et al., 2004).

These clients appear to need housing with additional supports and structure that focus on helping them learn the necessary skills to live independently. The Peer Supportive House is an example of a program that can serve to house and support this group of clients. This type of housing can be implemented as a next step in housing when the traditional HF approach is unsuccessful with clients.

It important to note that only perceived impacts were examined in the current study and in the second year of the program when it can be considered to still be in a pilot stage. As well, not all tenants of the Peer Supportive House experienced success living there. It will be important that an evaluation of the housing outcomes of tenants of the Peer Supportive House be conducted and include a focus on identifying the characteristics of tenants who achieve stability in this kind of housing.

Cross-Cutting Themes

Based on the evaluation findings, we identified the following cross-cutting themes and issues:

1. Since the implementation of the Peer Supportive House is very recent, it is not surprising that there is no clear shared understanding of the purpose and goals for both clients and key informants. In this case, the Peer Supportive House has two main goals, which are to house clients who have experienced chronic housing instability and to house clients who need temporary housing. The clients, who are housed temporarily, have the most difficulty understanding the objectives of the Peer Supportive House and are unclear that they are there for temporary reasons. Key informants have varied views concerning the goals associated with housing clients with chronic housing instability; some key informants emphasize the idea that the Peer Supportive House is transitional in nature with tenants working towards independent living in the community while other key informants view the house as providing permanent housing to its tenants.
2. Although the Peer Supportive House was implemented very recently, the program has encountered several challenges that appear to have been addressed in an effective manner. Key informants did report that they were still working on engaging some clients who were housed for reasons of chronic housing instability and this remained as the biggest challenge.
3. The superintendent couple in the Peer Supportive House were seen as invaluable sources of support by both clients and key informants. At the same time, they were not as valued to clients who were housed on a temporary basis as they waited for their own housing in the community. In this context, some of these clients viewed their presence as intrusive.
4. The Peer Supportive House appeared to be well-liked by clients and key informants who were interviewed. Few negative aspects were reported with the exception of those clients housed on a temporary basis who disliked the rules and presence of superintendents, and some did not like that they were asked to move.
5. It is clear that the Peer Supportive House is perceived by interviewed clients as having produced positive benefits. Most key informants also considered the house as yielding benefits for its tenants. Both groups viewed the house as producing a stabilizing impact (i.e., financially, psychologically, and medically) on clients.

Lessons Learned

The following lessons emerged from the current implementation evaluation of the Peer Supportive House:

1. The Peer Supportive House is perceived positively by clients and key informants in terms of it being helpful for individuals who have experienced chronic housing instability. On the other hand, it is viewed as being unhelpful and intrusive by clients who are housed on a temporary basis because of its expectations, rules, and structure. Therefore, it is recommended that the Peer Supportive House be reserved for individuals experiencing chronic housing instability.
2. Housing clients temporarily in order to remove them from a state of homelessness is important, but it is recommended that this be done in a separate building where the tenancies are managed in line with the core values of HF (i.e., no rules that threaten eviction, emphasis on independence, facilitation of empowerment and client-centred decision-making). One possibility is for the Moncton site to hold the lease on one or two apartments in the community and use these apartments to house clients on a temporary basis. In addition, it is important that all clients, who are housed temporarily, be made fully aware of the arrangement and be reminded regularly of it. This is a suggestion that emerged through client and key informant interviews.
3. Currently, the Peer Supportive House is organized in such a way that it seems to house some clients on a temporary basis and house other clients in a more permanent fashion. The ultimate goal of the house for those clients with chronic housing instability appears to be unclear to key informants and clients. Housing clients with chronic housing instability should be done with the ultimate goal of helping clients acquire skills to live independently. Housing could be organized in an open-ended fashion, geared to individual needs and with a focus on graduation into long-term independent housing (i.e., graduation could take months to years for certain clients).
4. Clients and key informants described the Peer Supportive House as being housing of a "last resort," such that if they were evicted from the house they could ultimately lose their rent subsidy. The loss of the rent subsidy does not fit with a HF approach, which is guided by a commitment to housing and supporting clients even in the context of them experiencing multiple evictions and long-term housing instability. Though key informants stated that the ACT team continued their efforts to engage and support clients who had been evicted from the Peer Supportive House, they stated that engagement with them had been mostly unsuccessful. In this context, it is recommended that a review process for clients facing eviction from the Peer Supportive House be implemented in order to ensure that they continue to receive the support that they need. If a client is unsuccessful in independent housing and subsequently at the Peer Supportive House, other housing alternatives should be considered including placement in a Special Care Home.
5. A logic model should be developed for the Peer Supportive House with input from the different groups of stakeholders (i.e., key informants, clients, and the superintendent couple). There should be a clear distinction in the logic model between housing for temporary reasons and housing for clients facing chronic housing instability. A shared understanding of the program theory will be beneficial to the functioning of the house and key informants will become better able to answer clients' questions.

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