From: Marlene W
To: Speaker Request
Subject: [EXT] Notes on Chez Nous and BC Housing Documents for CLR Kirby-Yung
Date: Tuesday, June 14, 2022 10:17:13 PM

Good evening, Speaker.

I have some notes available to comment on what Speaker 3 had said.

BC Housing used Chez Nous data to beef up their data.

Scattered housing is an apt in a market building not a congregate supportive BC Housing building.

Dr Julian Somers at SFU advocates scattered housing with ACT.

People are independent and free to make their own choices, but must agree to engage with an ACT team.

Marlene

Cross-Site At Home/Chez Soi Project

https://urldefense.com/v3/__https://www.mentalhealthcommission.ca/sites/default/files/mhcc_at_home_report_national_cross-site_eng_2_0.pdf__;!!G4oVokrRG-Im!6yELZT2c4yHD_SrUpQ_Nmn7xWSTtJF8uiL3W__2TXXN6SKgZYcJv8klQL_y1uW0l7TyHIrdDsQ$

Page 5 - Outcomes
Point 2
Housing First rapidly ends homelessness. Across all cities, HF participants obtained housing and retained their housing at a much higher rate than the treatment as usual (TAU) group.

In the last six months of the study, 62 per cent of HF participants were housed all of the time, 22 per cent some of the time, and 16 per cent none of the time;
whereas 31 per cent of TAU participants were housed all of the time, 23 per cent some of the time, and 46 per cent none of the time.

Findings were similar for ACT and ICM participants. Among participants who were housed, housing quality was usually better and more consistent in HF residences than TAU residences. We now know more about the small group for whom stable housing was not achieved by HF, and about some additions or adaptations that may work better for them.

Point 4
It is Housing First, it is not housing only. Most participants were actively engaged in support and treatment services through to the end of follow-up. The general shift away from crisis and institutional services to community-based services that was seen at 12 months continued for the duration of the study. Many individuals with previously unmet needs were able to access appropriate and needed services during the study.

Point 7
Getting Housing First right is essential to optimizing outcomes. Housing stability, quality of life, and community functioning outcomes were all more positive for programs that operated most closely to HF standards. This finding indicates that investing in training and technical support can pay off in improved outcomes. Other important implications for policy are discussed in this report. In addition, lessons learned have now been incorporated into a toolkit to guide the planning and implementation of effective Housing First programs in Canada.

Page 6
In 2008, the federal government invested $110 million for a five-year research demonstration project aimed at generating knowledge about effective approaches

for people experiencing serious mental illness and homelessness in Canada. In response, the Mental Health Commission of Canada (MHCC) and groups of stakeholders in five cities (Vancouver, Winnipeg, Toronto, Montréal, and Moncton) implemented a pragmatic, randomized controlled field trial of HF. The project, called At Home/Chez Soi, was designed to help identify what works, at what cost, for whom, and in which environments. It compared HF with existing approaches in each city. The examination of quality of life, community functioning, recovery, employment, and related outcomes was unprecedented, as was the inclusion of two types of support services for individuals with high needs (Assertive Community Treatment, or ACT) and moderate needs (Intensive Case Management, or ICM).

The study also used a standardized model of HF, conducted assessments of program fidelity to document the quality of program implementation, introduced quality assurance processes, and provided extensive training, technical assistance, and support.

A randomized trial design was used in the project because it could evaluate the effects of HF in groups that were virtually identical except for the intervention itself, thus giving the strongest evidence for policy. The study also included a qualitative research component to complement and better inform the quantitative results (mixed methods design). Data collection began in October 2009 and ended in June 2013. 2,148 individuals were enrolled for two years of follow-up and of those, 1,158 received the HF intervention. Follow-up rates at 24 months were between 77 and 89 per cent, which are excellent for a vulnerable and highly transient population.

This document reports on the main findings of the study for the full two years of follow-up. It builds on the At Home/ Chez Soi Interim Report (September 2012), which presented the preliminary one-year results.

Page 7
Study Participants
Most At Home/Chez Soi study participants were recruited from shelters or the streets. The typical participant was a male in his early 40s, but there was a wide diversity of demographic characteristics. Women (32 per cent), Aboriginal people (22 per cent), and other ethnic groups (25 per cent) were well-represented. The typical total time participants experienced homelessness in their lifetimes was nearly five years. Participants were found to have had multiple challenges in their lives that contributed to their disadvantaged status. For example, 56 per cent did not complete high school, and almost everyone was living in extreme poverty at study entry. All had one or more serious mental illness, in keeping with the eligibility criteria of the study, and more than 90 per cent had at least one chronic physical health problem. Using qualitative interviews with a representative sample and quantitative measures, we have documented the early origins of homelessness in the life histories of participants, which very often included early childhood trauma and leaving home to escape abuse.

Page 8
While the HF groups on average improved more on the major outcomes, the individual responses in both HF (ICM and ACT) and TAU over time were enormously diverse.
Across all sites in the qualitative interviews, 61 per cent of the HF participants described a positive life course since the study began, 31 per cent reported a mixed life course, and eight per cent reported a negative life course.
In contrast, only 28 per cent of TAU reported a positive life course, 36 per cent reported a mixed life course, and 36 per cent reported a negative life course. The study generated and consolidated rich information about different sub- populations, diverse responses, and how to successfully adapt the approach.

Page 12
The majority of the housing was provided through private market rental units, although, where available, participants were also offered a choice of supportive and/or social housing. Individualized, recovery-oriented supportive services were provided according to two levels of need by ACT (high need) and ICM teams (moderate need).

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The ACT programs were provided by multi-disciplinary teams that included a psychiatrist, nurse, and peer specialist among others. The ACT teams had a staff to participant ratio of 1:10. The ACT teams met daily, and staff was available seven days per week with crisis coverage around the clock.10
(If 140 residents, then 14 staff needed.)

• The ICM programs were provided by teams of case managers who worked with individuals and brokered health and other related services as needed. The staff to participant ratio was initially 1:20 but was later changed to 1:16 because the needs of the moderate needs group were greater than expected. ICM teams held case conferences at least monthly and services were provided seven days a week, 12 hours per day11.
(If 140 residents, 7 staff for 1:20 and 9 staff for 1:16).

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By comparison, the treatment as usual group had access to the existing housing and support services in their communities.
In some cities, this included a range of options, with other supportive housing programs and treatment resources available, while in other cities there were fewer options.

Page 13
Vancouver

One hundred participants were provided HF through a congregate site model at the Bosman Hotel, which is operated by the Portland Hotel Society. Participants had their own room and washroom, and access to individualized on-site health, mental health, and addictions services, including clinical care (nursing care, medication support), social support (groups, programming), and case management. Staff was available 24 hours a day, seven days a week and two meals were provided daily. Findings for those who received the congregate living "third arm" in Vancouver (at the Bosman) are excluded from this report because the program model differed in important ways from the main intervention. Findings for the congregate intervention are outlined in the Vancouver Final Report.

Page 14
62% ICM. 38% ACT
2148 participants- 1158 Tx, 990 Controls

Page 15
While 93 per cent were unemployed at the time of study entry, more than 66 per cent had worked steadily in the past. A small but important proportion (four per cent) of participants were veterans, having reported wartime service for Canada or an allied country

34 per cent had a psychotic disorder, 71 per cent had a non-psychotic disorder, and 67 per cent reported substance-related problems. A substantial proportion (46 per cent) had more than one non-substance- related mental illness and a majority (73 per cent) had more than one mental illness including a substance-related illness (any of alcohol or drug dependence or use).

Page 16
Over one-third (36 per cent) reported involvement with the criminal justice system in the six months prior to the study, having been arrested, incarcerated or served probation one or more times. The HN group reported more involvement with the justice system than the MN group (43 per cent versus 30 per cent). With respect to the type of legal system involvement,
24 per cent of participants reported being detained or moved along by police, 22 per cent reported being held by police for less than 24 hours, 27 per cent reported being arrested, 30 per cent reported having had a court appearance, and 11 per cent reported participation in a justice service program in the prior six months.
Many participants also experienced victimization in the six months prior to study entry:
32 per cent reported being robbed or threatened to be robbed, 43 per cent reported being threatened with physical assault, and 37 per cent reported being physically assaulted.

General distress levels were also high, with 36 per cent reporting symptoms consistent with moderate to high suicide risk. (Note that there were standard referral processes that were followed in the study if a participant was deemed at risk of suicide.)

Page 17
Over the course of the At Home/Chez Soi study, more than 200 service providers were involved, over 260 landlords and property management companies recruited, and over 1,200 housing units located. This intensive effort had enormous direct impact on the housing circumstances of participants. 1,158 individuals randomly allocated to the HF group received housing and comprehensive supports. The 990 participants who were randomized to TAU had access to the range of treatment and housing services available in their communities.

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Page 19:
However, even though the majority of HF participants became stably housed, housing stability was not achieved for a small group (13 per cent). This group was found to have longer lifetime histories of homelessness, to be less likely to have completed high school, to report a stronger sense of belonging to their street social network/better quality of life while homeless, and to present with more serious mental health conditions.

In particular, participants who did not achieve housing stability in the first year reported having been homeless for 8.75 years over their lifetime compared to 5.70 years for those participants achieving housing stability. Almost two-thirds (66 per cent) of participants in the non-stable housing group had not completed high school compared to 55 per cent of participants who achieved stable housing in the first year.

Page 20
For example, in Moncton, peer-staffed congregate housing was found to be necessary for some of those who had additional needs and were not doing well in independent apartments despite several relocations. Another approach in Winnipeg involved the use of transitional apartments on one floor of a secure residential apartment building for those who had to learn how to prevent unwanted guests from intruding and creating difficulties with neighbours and for the tenant.

HF in its classic format is not a panacea — a small number of individuals' mental health and medical needs, and/or level of functioning are such that they are best served in living arrangements where a more intense level of support and more structure can be provided.

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Page 20
Landlord Engagement
The takeover of apartments by former acquaintances, who then engaged in drug and alcohol related activities that were disruptive for the

tenant and neighbours and damaged the property, is an example of a tenancy challenge that support staff and landlords had to manage. Much was learned about how to work in partnership with landlords and these learnings are outlined in the forthcoming Housing First Toolkit.

In Moncton, landlords stated that program tenants were, in many instances, as good as or better than other tenants. Landlords in Vancouver had positive experiences with the "fit" of tenants in their buildings, and landlords in Winnipeg talked about having good relationships with the housing team despite considerable tenancy challenges.

57 out of 260 landlords participated in qualitative interviews.

Pages 21-22
Lower use of drop-in centres for meals and other services needed by participants was also noted for the HF group (Figure 7); however, the use of food banks appeared to be higher for both HN and MN participants (Figure 8). This is not surprising, given that many food banks require a fixed address in order to provide a hamper. Also, housed individuals were able to store food and prepare meals. Across sites, many HF participants found that having stable housing (and, for many, associated financial stability) was paramount to improving their eating patterns, since they could finally purchase and store food and supplies for themselves.
Given that community-based service delivery by providers (e.g. in-person visits and phone calls) was an intentional and essential part of the intervention, we expected to find greater frequencies of these events in the HF group relative to TAU, and that is what was found. The details of these service patterns are not provided here, but they are included in the comprehensive economic analysis in the next section.

Page 22:
Justice Service Use
Over the complete follow-up period, contact with the justice system was common for both the HF and TAU groups. During this period, the majority (89 per cent) had at least one interaction with police officers, which could involve help-seeking, information requests or criminal activity. Around one third of participants
were actually arrested during the study timeframe. Both HF and TAU groups reported substantial declines in their contacts with justice services (police, security services, courts, and other justice services), with no significant difference between the groups. When reasons for arrests were investigated, however, HF participants reported fewer arrests for public nuisance offences and drug- related offences over time, whereas TAU participants reported no such decline.

Page 24:
The total costs offset for this group, along with one significant increase, are illustrated in Figure 14. The most significant cost offset is psychiatric hospitalizations: the HF intervention is able to prevent subsequent psychiatric hospitalizations to a much greater extent than usual services. This
is not surprising, as many studies have shown that ACT teams, in particular, are consistently effective at reducing both numbers of admissions and length of
stay for people who tend to spend a considerable amount of time in psychiatric wards.19 At the same time, this high cost group tended to have more stays in psychiatric residential facilities.

Page 31:
Getting Housing First right is essential to optimizing outcomes. Housing stability, quality of life, and community functioning outcomes were all more positive for programs that operated most closely to Pathways HF standards. (Chapter 6)

Pathways to Housing First
https://urldefense.com/v3/__https://pathwaystohousingpa.org/sites/pathwaystohousingpa.org/files/Pathways*20Housing*20First*20Evidence-based.pdf__;JSUl!!G4oVokrRG-Im!6yELZT2c4yHD_SrUpQ_Nmn7xWSTtJF8uiL3W__2TXXN6SKgZYcJv8klQL_y1uW0l7TwT9z8faA$

https://urldefense.com/v3/__https://policywise.com/wp-content/uploads/2016/08/Community-Action-Pathways-to-Housing.pdf__;!!G4oVokrRG-Im!6yELZT2c4yHD_SrUpQ_Nmn7xWSTtJF8uiL3W__2TXXN6SKgZYcJv8klQL_y1uW0l7Tw1cfULOQ$

The Social and Economic Value of Scattered-Site Supportive Housing in B.C. A Social Return on Investment (SROI) Analysis

https://urldefense.com/v3/__https://www.bchousing.org/research-centre/library/tools-developing-social-housing&page=1&sortType=sortByDate__;!!G4oVokrRG-Im!6yELZT2c4yHD_SrUpQ_Nmn7xWSTtJF8uiL3W__2TXXN6SKgZYcJv8klQL_y1uW0l7Ty9mqSU_Q$

BC Housing helps people experiencing homelessness by providing investment for community-based non-profits to provide programming

and rent supplements for market housing (scattered-site supportive housing) through the Homeless Outreach and Homeless Prevention Programs (HOP and HPP).

HPP focuses on providing support to people leaving corrections and hospital systems with no other place to stay, women who have experienced violence or are at risk of experiencing violence, youth transitioning out of the foster care system, and people of Indigenous descent

5 Cases of Supportive Scattered Housing in Market Housing Developments
BC Housing engaged accredited Social Return on Investment (SROI) practitioners at Constellation Consulting Group to assess the social and economic value created by scattered-site supportive housing, using the internationally standardized SROI methodology.

SROI analysis combines quantitative, qualitative, and participatory research techniques to demonstrate the value of outcomes from different stakeholder perspectives. The end result is an SROI ratio that compares investment to the financial value of social outcomes achieved, showing — in monetary terms — the financial benefit of social investments.

The methodology articulates the financial value of outcomes created through a social investment, revealing how much social and economic value is created for every dollar invested.

An SROI analysis combines quantitative, qualitative, and participatory research techniques to demonstrate the value of outcomes from different stakeholder perspectives.

The SROI analysis of each case study follows the methods outlined in A Guide to Social Return on Investment, The Social Value Network International's acknowledged international SROI methodology guidance document.

Approximately 1-2% of the value is estimated to go back to local communities and neighbourhoods.

An additional 1-2% of the value returns directly to landlords.

Page 10
According to a 2010 review of supportive housing programs, supportive housing generally, though not always, includes:13
› Choice in housing options
› Resources in close proximity
› Affordable rent (not more than 30% of income)
› Limited requirements to maintain housing (such as sobriety and housing is not jeopardized if hospitalized)
› Individualized and flexible support
› Crisis services available 24/7
› Tenancy agreements similar to those used in the private rental housing market (but rent may be paid directly through a service provider, and involves a housing subsidy)
› Private access to a unit and privacy in unit › Immediate placement into housing (i.e. no
prerequisite conditions for receiving housing)

Page 12
The scattered-site supportive housing case studies in the current research specifically target people who are homeless or at immediate risk of homelessness, particularly people leaving the corrections and hospital systems; women who have experienced violence or are at risk of experiencing violence; youth (including those leaving the care system); and people of Indigenous descent.

Page 15
For groups who are particularly vulnerable when experiencing homelessness, such as women, youth, children, and seniors, the positive outcomes from supportive housing are amplified: 27
› Women experience significant increases in safety from violence and avoidance of possible sex trade involvement when housed in supportive housing
› Pregnant women experience increased ability to maintain positive health during pregnancy (such as decreased substance use and improved nutrition), which has a positive impact on their babies
› Youth (particularly youth transitioning from foster care) experience increased safety from violence and decreased like- lihood of becoming involved in sex trade, drug trade, or drug use. Youth also experience increased ability to engage in education, vocational training, and employment, reducing the opportunity cost otherwise experienced while homeless and precariously housed
› Children experience significant improvements in health and wellbeing, increased ability to engage in school, and decreased adverse childhood experiences (including abuse, violence, and toxic stress)
› Seniors experience increased safety, increased ability to maintain their health, and decreased likelihood of experiencing elder abuse

This report builds on the extensive and rigorous body of research investigating outcomes from supportive housing to ensure the correct outcomes are valued and the impact is not over-claimed in the SROI models. In particular, we leveraged learnings and results from the Vancouver findings in the rigorous Canada-wide National At Home/Chez Soi Study conducted in 2014.28

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Page 17
Rather than seeking to create new research on the cost of homelessness, this report leveraged existing research to understand the value to government of reduced service use when individuals move from homelessness to supportive housing. The At Home/Chez Soi findings as explored by Stergiopoulos, V. et al. (2015) were used to estimate government service cost savings due to supportive housing, because:

› The research was based in Canada (most other cost studies are based in the United States) › It examines outcomes and costs local to B.C. (Vancouver, specifically)
› It is one of the most recent studies available (2015)
› It is based on rigorous methods (RCT)
› It includes a thorough investigation of costs (including 400 cost data points)
Limitations of utilizing this research to understand government costs for the current study are explored in Section 6.0.

Page 17
The SROI ratios vary considerably in the studies reviewed, from the low end indicating that for every dollar invested supportive housing creates approximately three dollars in social and economic value to the high end indicating that for every dollar invested supportive housing creates approximately 15 dollars in social and economic value.

Page 18 - Kelowna model - 2 years of data

Housing First stream - 1 year, 90% stay, 10% homeless
Youth stream - 1 year
Community navigation stream - 19 months

$1 = $4.50
›11 of 54 residents, including a mix of men and women from different CMHA Kelowna housing streams
Unfortunately, no community stakeholders, such as service providers or business community members, were available for engagement during the study period. (See Appendix D for interview questions and Appendix B for a list of stakeholders engaged in each case study.)

Page 25 - Mid-Vancouver Island (Nanaimo)
Page 27 - 1 resident out of 30 interviewed
$1 = $3.50
Page 30
Approximately 42% of the social and economic value goes back to residents through increases in wellbeing, increased safety, increased disposable income, and reduced harm. This indicates that, while scattered-site supportive housing creates important value for the government, it also generates significant value for people living in supportive housing, whose lives are directly impacted by the positive outcomes they experience as a result.

Page 31 - The Lookout
Page 32 - average length of stay is 7 months
Page 36
Lookout's HPP program creates important added value through its support for families, who, without supportive housing, are at greater risk of experiencing violence, abuse, and long-term negative outcomes.
$1=$4.50

Page 38 - MPA Society
Supported Independent Living program (SIL), Super SIL (SIL with additional supports), and the Supported Outreach Living Opportunities (SOLO) program. This analysis examines the social and economic value created by the SOLO program as it is supported by HPP and HOP investment through BC Housing.

While the SOLO program was not initially designed as a Housing First model, it now operates using a Housing First approach after Housing First's effectiveness was shown by the Vancouver At Home/Chez Soi study, in which MPA Society was involved. SOLO's goal is to support participants in maintaining as high a level of independence as possible while residing in the community of their choice. Currently, SOLO works with 160 participants across Greater Vancouver.

Page 39
The SROI analysis has been informed by key stakeholders who were engaged via in-depth interviews, including: › 10 of 160 residents, including a mix of men and women
› Three service and community partners (Ministry of Social Development and Poverty Reduction; St. Paul's mental health team through Providence Health; Coordinated Access through BC Housing)
› Two landlords/property managers
(See Appendix D for interview questions and Appendix B for a list of stakeholders engaged in each case study.)

Average stay 4 years. $1=$3.50.

Page 46 - Pacifica - Victoria

Average length of stay 3 years
Page 47
The SROI analysis has been informed by key stakeholders who were engaged via in-depth interviews, including:
› 10 out of 286 residents, including a mix of men and women
› Three landlords and property managers
No community stakeholders (such as service providers or business community members) were available for engagement during the study period. (See Appendix D for interview questions and Appendix B for a list of stakeholders engaged in each case study.)
$1=$3.75

Sent from my iPhone