# IMPROVING HOUSING AND RECOVERY OUTCOMES FOR DISADVANTAGED POPULATIONS: EVIDENCE TO INFORM POLICY AND PRACTICE

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# Objectives

- To review findings of a large multisite randomized trial of Housing First

- To discuss opportunities for practice and program improvements

# Background

- More than 30,000 people are homeless in Canada on any given night and over 200,000 Canadians are homeless  each year.
- In Toronto, there are ~5,200 homeless people each night, >27,000 shelter users each year.
- People who are chronically homeless experience high rates of chronic health conditions and premature mortality

The State of Homelessness in Canada, CHRN 2013; Street Needs Assessment 2013
Fazel et al, 2014; Hwang et al, 2011; Stergiopoulos et al, 2015

# Mental Health and Homelessness

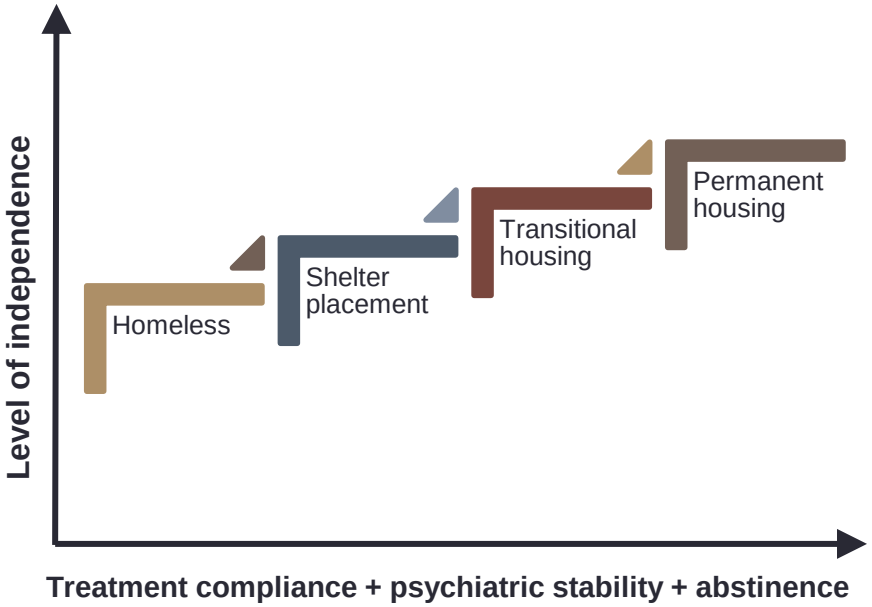
- The prevalence of mental health problems among people who are homeless is high, with a pooled prevalence estimate of 12.7% for psychotic disorders and 11.4% for mood disorders such as major depression (Fazel et al., 2008).

- People who are homeless experience high rates of neurocognitive impairment

- Rates of mental illness and addictions much higher among those experiencing chronic homelessness.

The State of Homelessness in Canada, CHRN 2013; Street Needs Assessment 2013
Fazel et al, 2014; Hwang et al, 2011; Stergiopoulos et al, 2015

# Housing First




Traditional treatment trajectory


Housing First

Tsemberis, 2004 AJPH

# Housing First Model

Rapid placement in permanent independent housing

- no need to demonstrate “housing readiness” (e.g. sobriety)

Participants are treated like regular tenants with typical leases

- rent supplements are provided to reduce barriers; ≤30% of client income used for rent

Services are provided offsite and not tied to tenancy

- one weekly visit by service team

Care is individualized and consumer driven

- recovery-oriented and harm reduction approach

Tsemberis, 2010 AJPH

# At Home/Chez Soi Study

- In 2008, the Federal Government of Canada invested $110 million with the Mental Health Commission of Canada

- 4-year research demonstration project in 5 cities (Vancouver, Winnipeg, Toronto, Montreal, Moncton)


**Study Objectives:**

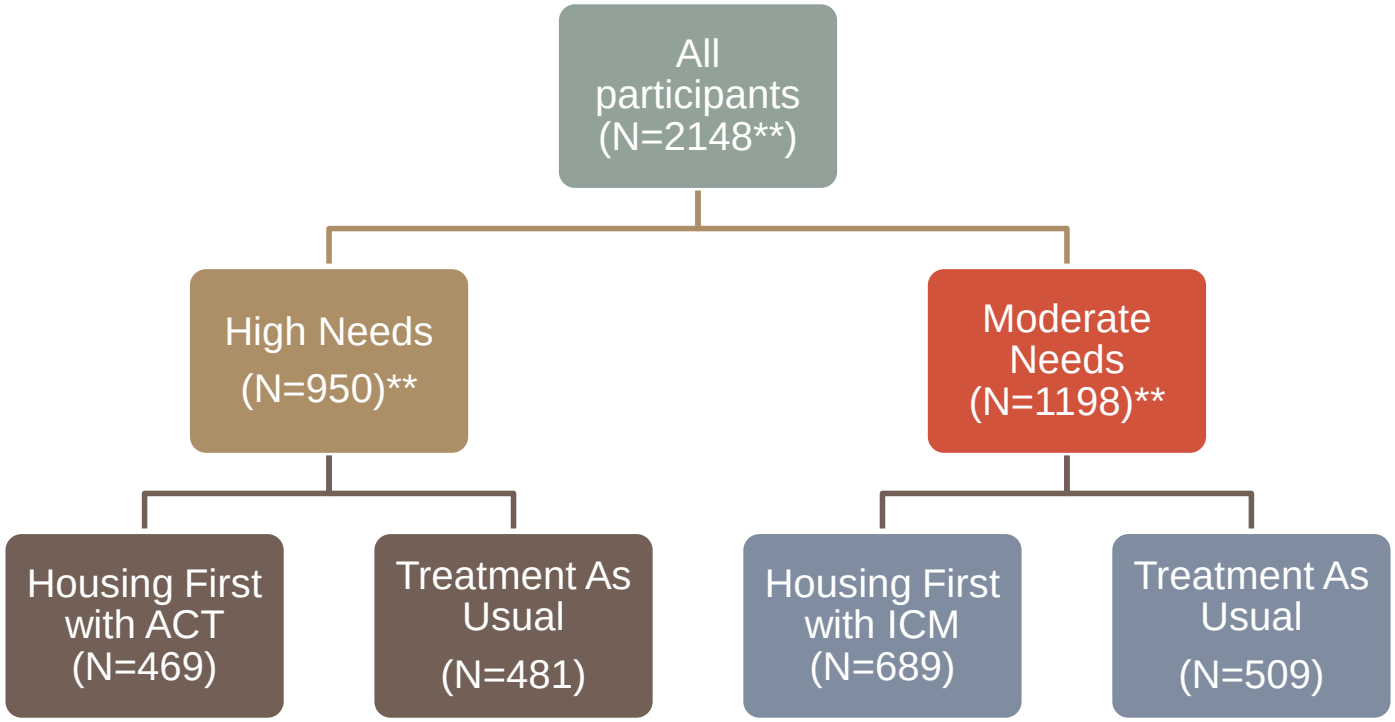
To determine the effectiveness and cost-effectiveness of a Housing First intervention for homeless people with mental illness

Goering et al, 2011 BMJ Open

# Study Eligibility

- ≥18 years old
- Literally homeless OR “Precariously housed”
- Presence of serious mental disorder with or without coexisting substance use problem
- Not currently receiving Assertive  Community Treatment (ACT) or Intensive Case Management (ICM)
- Eligible to receive public benefits (i.e., legal status)

# At Home: Randomization




**Although in total 2250 participants were enrolled in the study, some were excluded from the analyses from the Moncton and Vancouver sites. At the Moncton site, both moderate and high needs participants were randomized to HF+ACT or TAU while a group of participants at the Vancouver site were randomized to receive single-site Housing First with ICM services.

# Ethical Issues

## Randomization

- TAU group has access to services and supports in the community

## Informed Consent

## Risks vs. Benefits

- Disappointment if TAU
- Indirect benefit: Evidence creation
- Having research staff listen to their personal stories
- Honoraria (larger for TAU)

# Adapting Housing First Across Sites

## Site Specific Adaptations

- Vancouver: Congregate Housing
- Winnipeg: Aboriginal (Native Indian)-specific ICM team
- Montreal: Social Housing
- Moncton: Rural homelessness and all participants (moderate and high needs) received HF with ACT
- Toronto: Ethno-Racial ICM

## Involvement of Persons with Lived Experience (PWLE)

- Each site had a unique approach to the involvement of PWLE in project

# Implementing HF Across Sites: Successes

## I) Community factors

- Partnerships with government agencies to secure housing units, mental health/homeless services and government income supports
- Partnerships with landlords were instrumental to facilitation for the amount of apartments needed for project

## II) Training and technical assistance provided by the MHC

- Training was seen as supportive and relevant
- MHCC was seen as fair, responsive and generous
- Presence of Site Coordinator at each site (acts as facilitator/change agent/boundary spanner)

## III) Organization/team/service factors

- Project leads in all areas had necessary skills that helped implementation
- Skilled teams and team cohesion
- Organizational structure/governance was important to defining roles/responsibilities
- Partnerships with consumers was important to establishing positive consumer-staff relationships in addition to facilitating implementation

## IV) Characteristics of the innovation

- Site-specific programs to address needs of specific populations were seen as part of success of project

Nelson et al, 2015

# Implementing HF Across Sites: Challenges

## I) Community factors

- Lack of affordable/available housing led to housing delay
- Challenges related to partnerships with some landlords included stigma and racism and sustaining/repairing of relationships with landlords, after evictions, etc.

## II) Training and technical assistance provided by the MHC

- Mixed views on training with some wanting a greater degree of sensitivity training
- Staff was also not prepared for the number of participants who moved out and needed new housing arrangements

## III) Organizational/team/service factors

- Lack of contact/cohesion between teams (for example housing and service teams)
- Staff workload issues and caseload size
- At some sites there was a lack of communication of the role of peer/consumer involvement

## IV) Characteristics of the innovation

- Addressing needs of radicalized groups was a challenge, including providing cultural appropriate housing and hiring cultural competent staff

Nelson et al, 2015

# The Participants

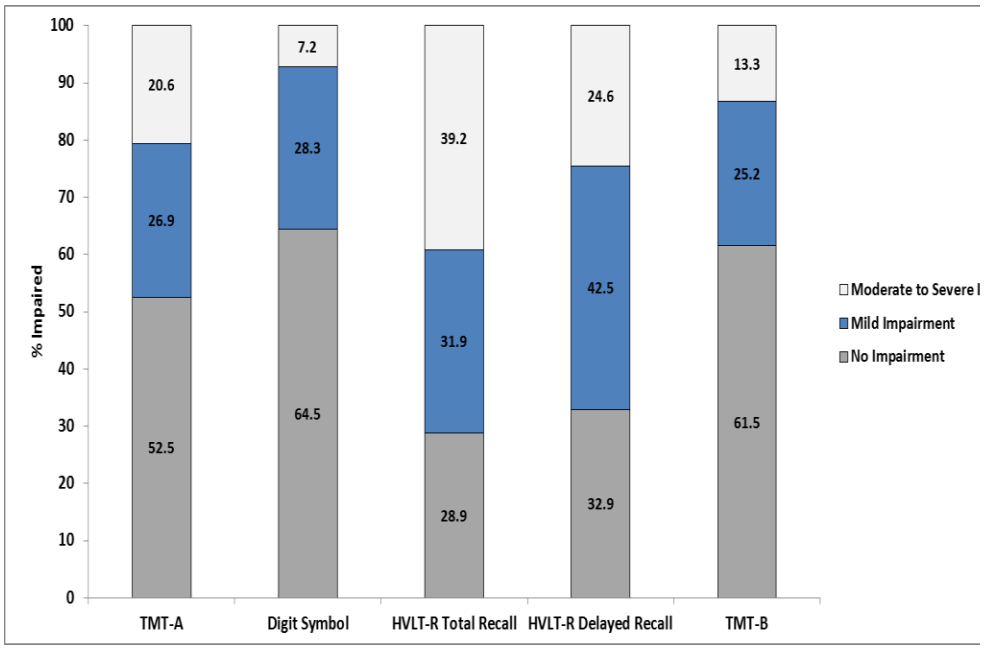
Most participants recruited from shelters or the streets

Wide diversity of demographic characteristics

Most participants experienced severe and multiple disadvantage:

- Extreme poverty
- Early childhood trauma
- 56% did not complete high school
- >90% had at least one chronic physical  health condition

# Level of neuropsychological impairment




- 72% of participants demonstrated cognitive impairment, including deficits in processing speed (48%), verbal learning (71%) and recall (67%), and executive functioning (38%).

- Reduced neurocognitive performance was associated with older age, lower education, first language other than English or French, Black or Other ethnicity, and the presence of psychosis

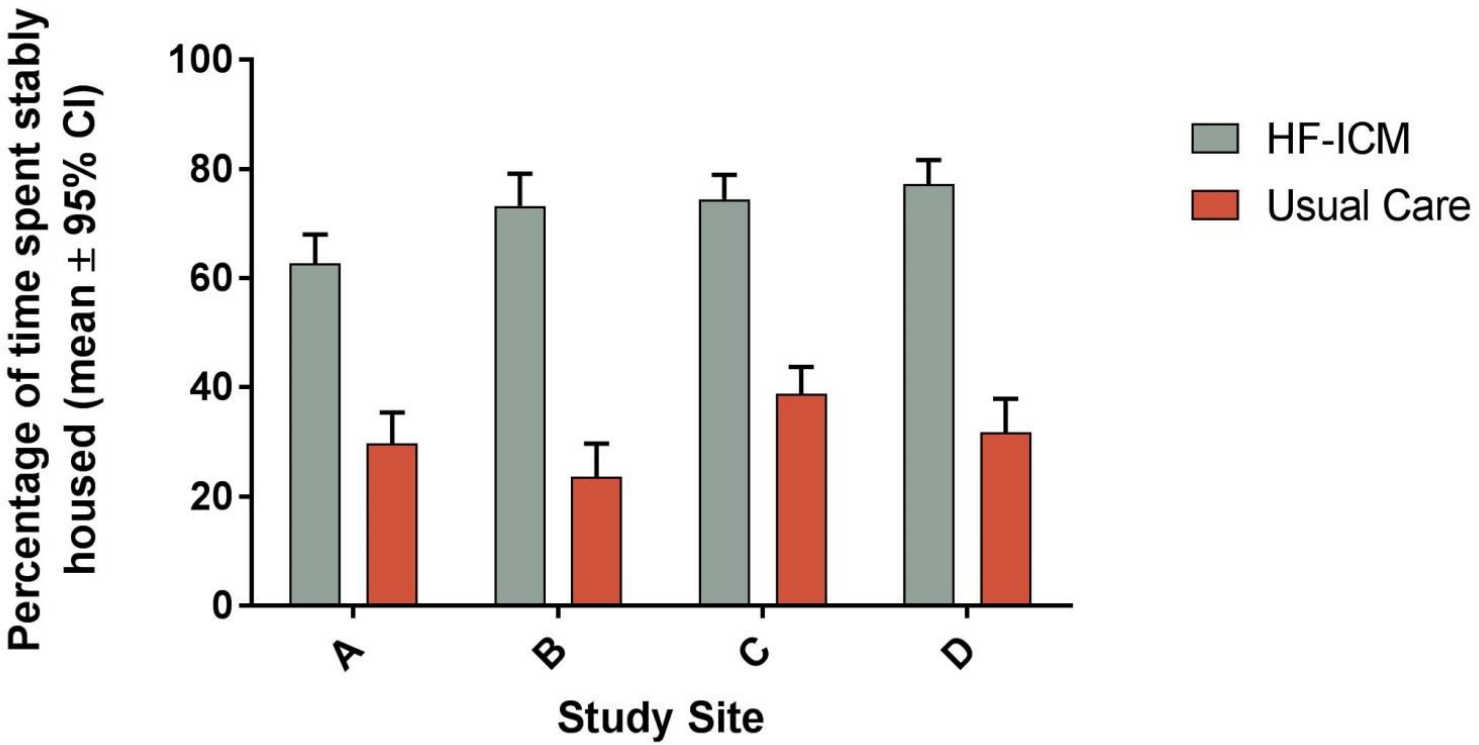
Stergiopoulos et al, 2015 Acta Psychiatrica Scandinavica

# At Home: Moderate Needs (n=1198)

| Characteristics | HF-ICM (n=689) | Usual Care (n=509) |
|---|---|---|
| **Age, years, mean (SD)** | 42.2 ± 11.1 | 42.1 ± 11.3 |
| **Male** | 65% | 68% |
| **Single/never married** | 68% | 68% |
| **Member of Ethno-Racial minority** | 27% | 29% |
| **Aboriginal** | 25% | 22% |
| **Lifetime duration of homelessness, years, mean (SD)** | 4.7 ± 5.9 | 4.4 ± 5.1 |
| **Less than High School education** | 54% | 50% |
| **MINI Diagnostic Categories** | | |
| **Depressive Episode** | 59% | 59% |
| **Post-Traumatic Stress Disorder** | 32% | 31% |
| **Panic Disorder** | 24% | 27% |
| **Psychotic Disorder** | 21% | 23% |
| **Alcohol Dependence** | 35% | 37% |
| **Substance Dependence** | 41% | 41% |

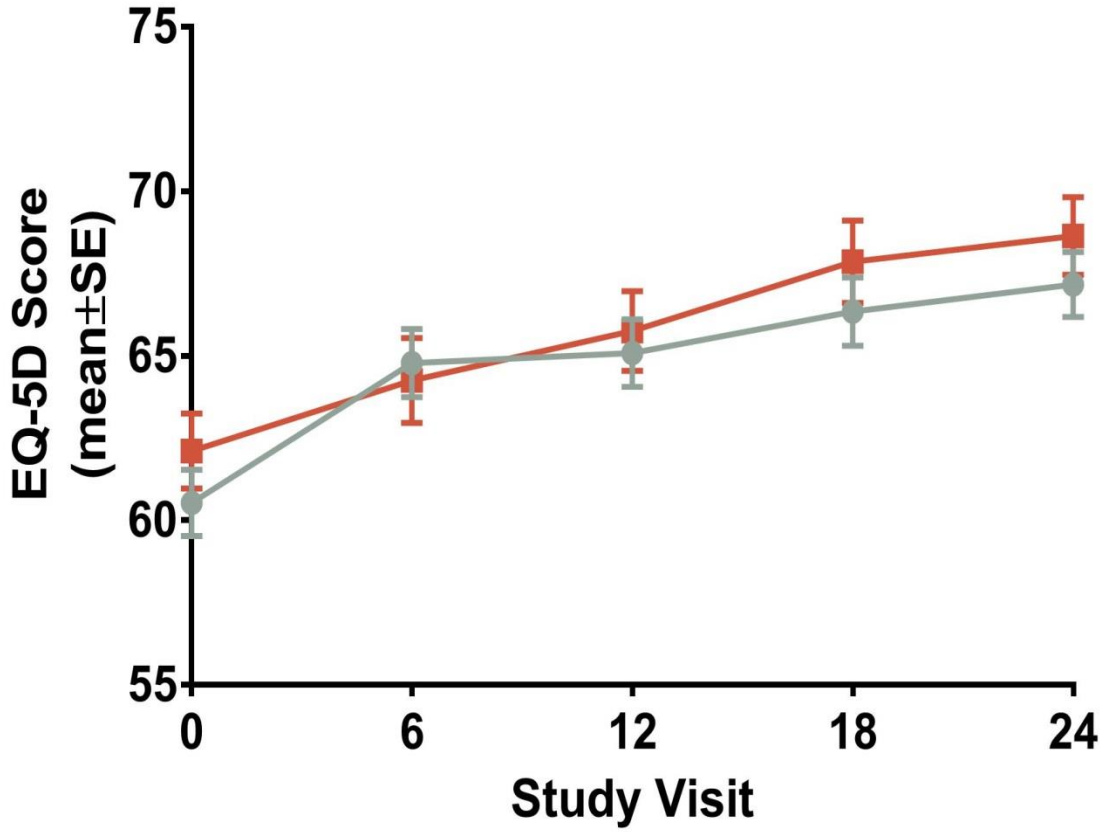
Stergiopoulos et al., 2015 JAMA

# Housing Stability: HF-ICM vs. TAU




Stergiopoulos et al, 2015 JAMA

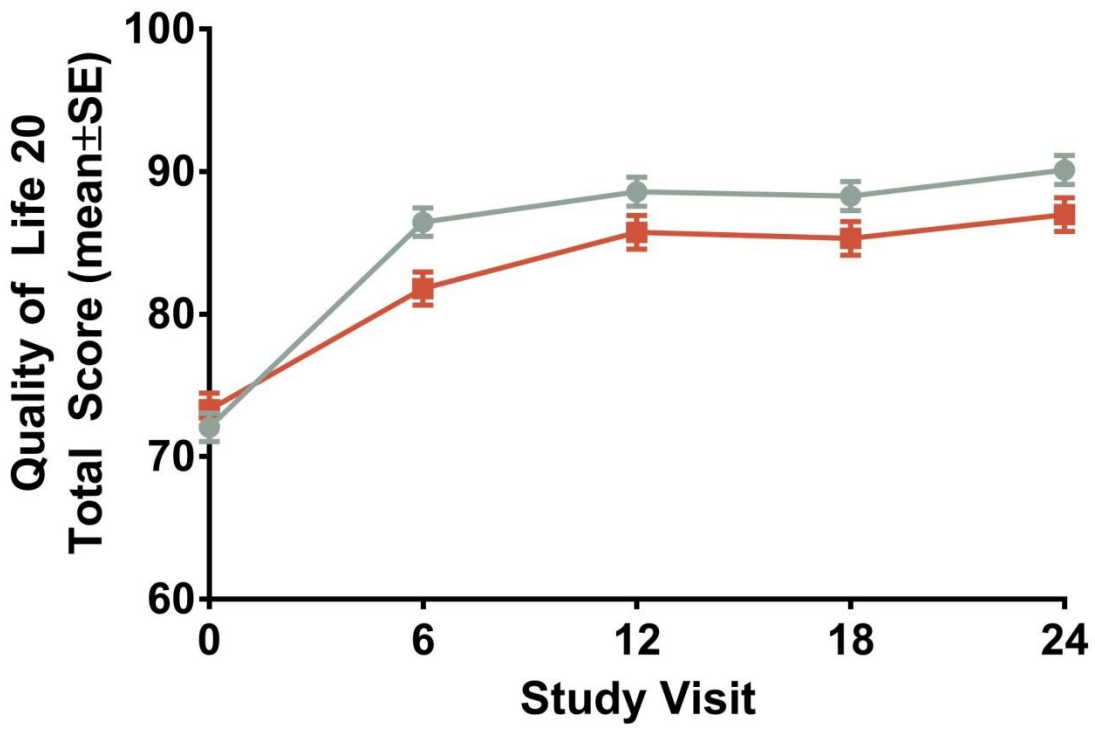
# EQ-5D: HF-ICM vs. TAU




*P*=0.95 at 24M

Stergiopoulos et al, 2015 JAMA

# Quality of Life: HF-ICM vs. TAU




*P*=0.002 at 24M

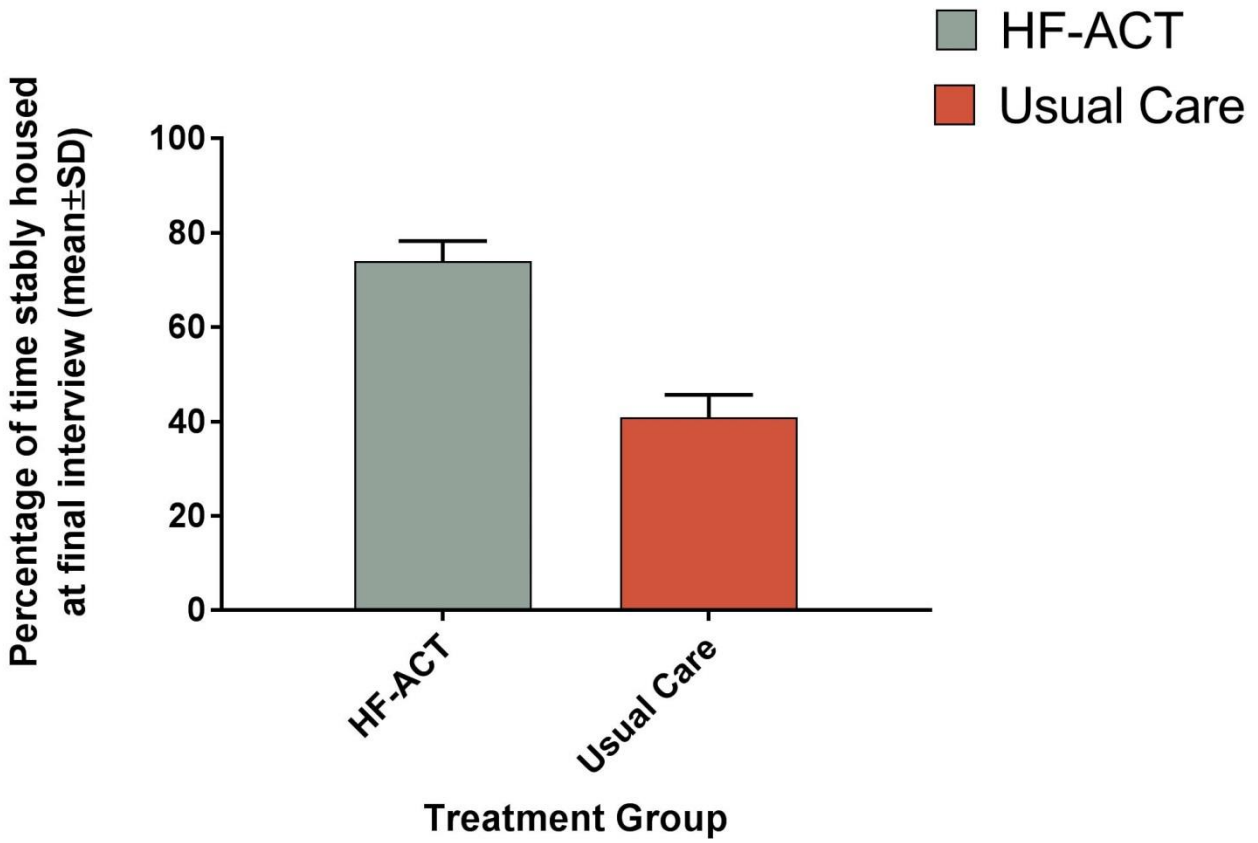
Stergiopoulos et al, 2015 JAMA

# At Home: High Needs (n=950)

| Characteristics | HF-ACT (n=469) | Usual Care (n=481) |
|---|---|---|
| **Age, years, mean (SD)** | 38.9 ± 10.8 | 39.9 ± 11.2 |
| **Male** | 68% | 68% |
| **Single/never married** | 73% | 74% |
| **Member of racial/ethnic minority group** | 20% | 21% |
| **Aboriginal** | 19% | 19% |
| **Been homeless >2 years lifetime** | 60% | 58% |
| **Less than High School education** | 58% | 60% |
| **MINI Diagnostic Categories** | | |
| **Depressive Episode** | 42% | 44% |
| **Post-Traumatic Stress Disorder** | 25% | 29% |
| **Panic Disorder** | 20% | 23% |
| **Psychotic Disorder** | 50% | 53% |
| **Substance Use Related Disorder** | 71% | 75% |

Aubry et al, 2016, Psychiatric Services

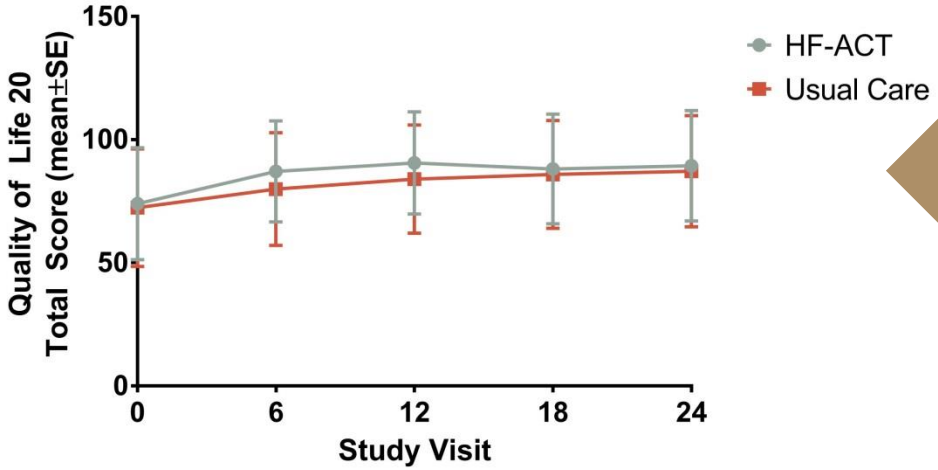
# Housing: HF-ACT vs. TAU




Adjusted absolute difference: 41.7%, 95% CI=37.9-45.4%, *P*<0.01

Aubry et al., 2016 Psychiatric Services

# QoL & Community Functioning: HF-ACT vs. TAU

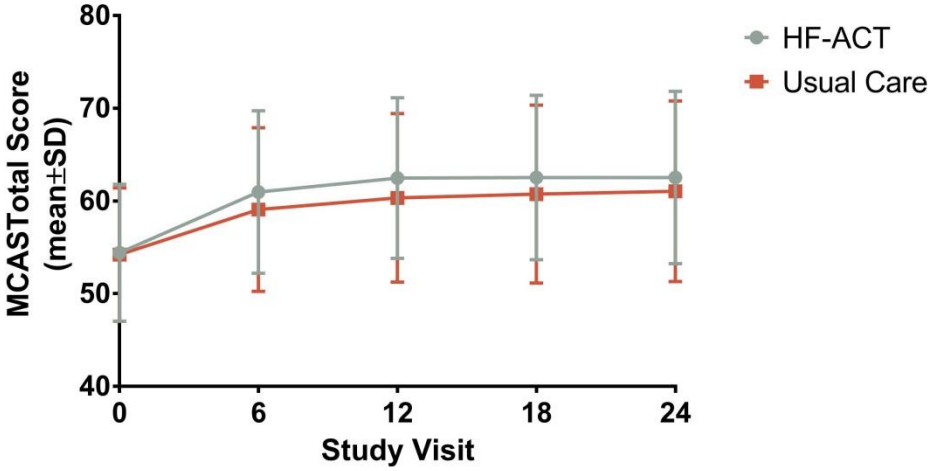



Across all follow-up visits *P*<0.01

At final interview *P*=0.15

Across all follow-up visits *P*<0.01

At final interview *P*=0.43




Aubry et al., 2016 Psychiatric Services

# Diversity in Toronto

- Toronto is Canada's most populous and ethnically diverse city; nearly half population cites ethno-racial ethnicity
- Half of all Toronto residents are immigrants
- Almost half (45%) shelter or meal program users identified as belonging to a non-White ethnic group, most commonly Black (22%), and Aboriginal (9%)
- About ⅓ of people experiencing homelessness in Toronto are immigrants , with particular barriers to accessing services related to race, language and social stigma

Statistics Canada 2008; Toronto: Social Planning 2009; Hwang et al, 2010

# Access to Care in Ethno-Racial Populations

Studies from Canada, US, UK and Australia suggest that immigrant and ethno-racial groups use mental health services less frequently compared to non-immigrants and experience significant barriers to care

Bhui, Warfa et al. 2007; Simich, Maiter et al. 2009

Higher rates of mental health problems have been observed in immigrants, refugees and ethno-racial individuals in Canada and worldwide.

Bhui and Sashidharan 2003; Kisely, Terashima et al. 2008;Hansson et al., 2012

**Reduced service use/access to services among immigrant and ethno-racial groups could result from:**

- distinct perspectives about mental health and illness;
- culturally unique methods of expressing mental health problems;
- a desire for more culturally appropriate alternative interventions and treatment;
- perception of coercive treatment approaches;
- lack of understanding of the need for culturally appropriate approaches among programs and providers

Snowden and Yamada .2005. Annu Rev Clin Psychol 1: 143-166.

# Adapting Housing First in Toronto

## Involvement of People With Lived Experience (PWLE)

Engagement from people with lived experience of homelessness and mental illness in all aspects of the project

- Initial community meetings
- Non-profit community agency with knowledge and experience- focus groups

PWLE Caucus formed at Toronto site, comprised of individuals with lived experience of mental illness and/or homelessness

- Advisory role
- Research role

## Ethno-Racial Housing First

Third-arm of Toronto site

Mental health case management agency focused on serving ethno-racial groups

Anti-Racism/Anti-Oppression framework

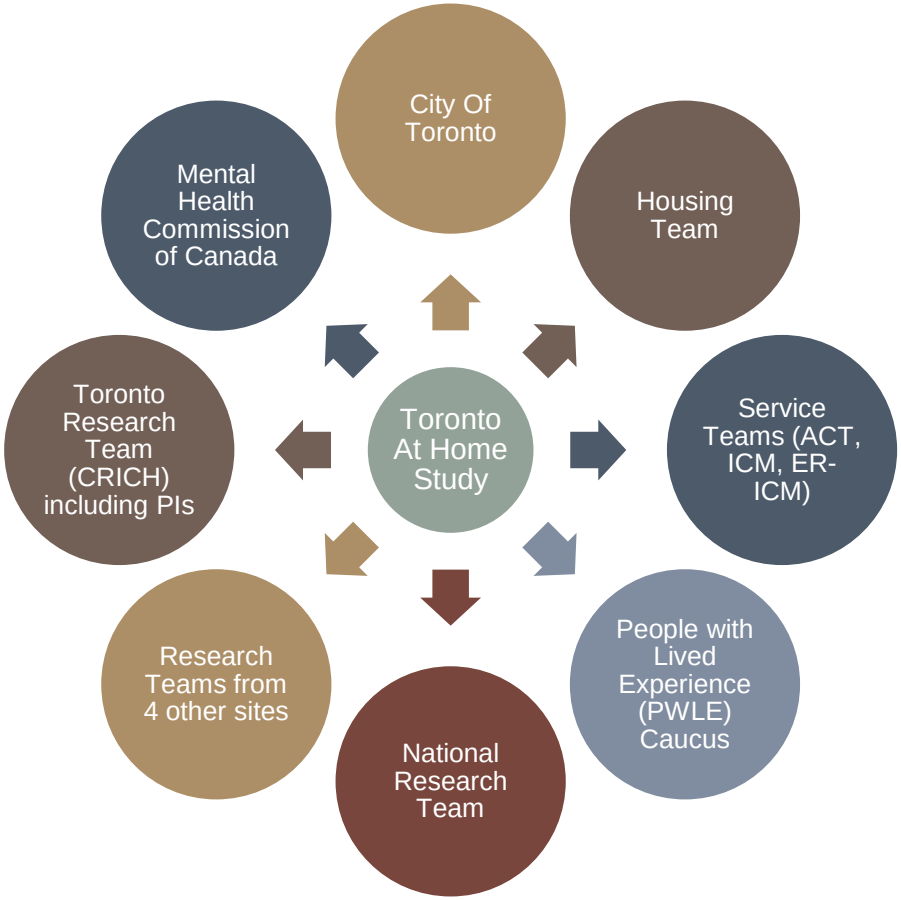
Staff representative of diverse ethno-racial groups

Linguistic accessibility

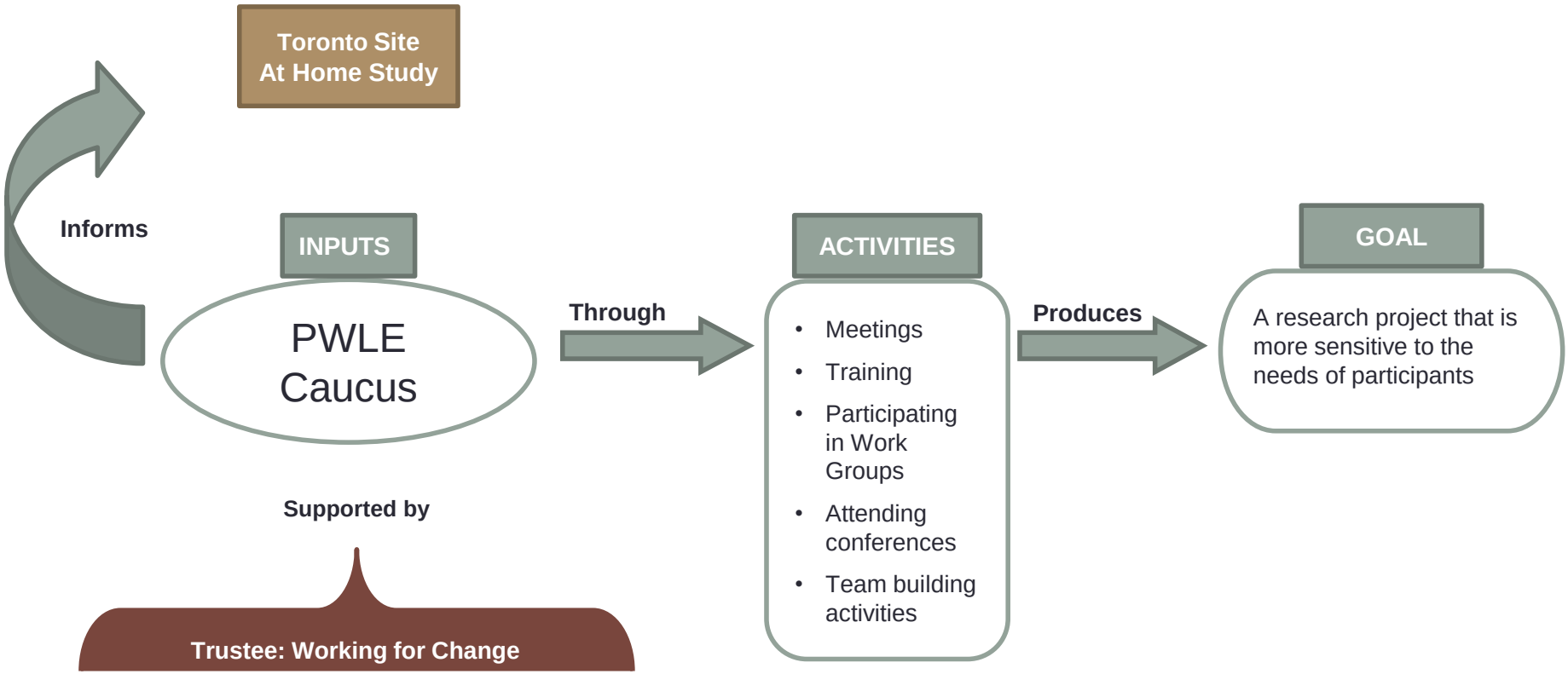
Culturally accessibility

Community kitchen

# Collaboration: Toronto Project Partners



# Inclusion of PWLE




vanDraanen et al, 2014, Psych Rehab J

# Lessons Learned

- Be purposeful and intentional about participation
- The importance of language
- Involve early
  - Agree on terms and clarify roles and responsibilities right away
- Regular “check-ins”
  - Environment of healthy debate
- Clarify agendas
- Bringing it back to the essentials

# Challenges to Meaningful Inclusion

Resources

Accommodations

Representation / selection of consumers

Growth and development over time

# Anti-Racism and Anti-Oppression Practices

Anti-oppression: a theory that guides practitioners' actions in the health/social services field that specifically tackle power and the access of resources.

Anti-oppressive practices put the consumer's perspective at the forefront; the importance of including, engaging and supporting consumers in every phase of service delivery.

Anti-racism: can represent a **social movement** as well as a **set of practices** and **discourses** aiming at tackling the whole spectrum of ways and sites where racism is embodied.

The **difference** between anti-oppression and anti-racism : the former does not predefine oppression from a specific category, whereas the latter takes race/racism as the point of entry in its analysis of oppression, power and privilege.

Corneau and Stergiopoulos, Transultural Psychiatry, 2012

# How Anti-oppression and Anti-racism Translate into Program and Practice?

7 main strategies to ‘do’ and use anti-oppression and anti-racism:

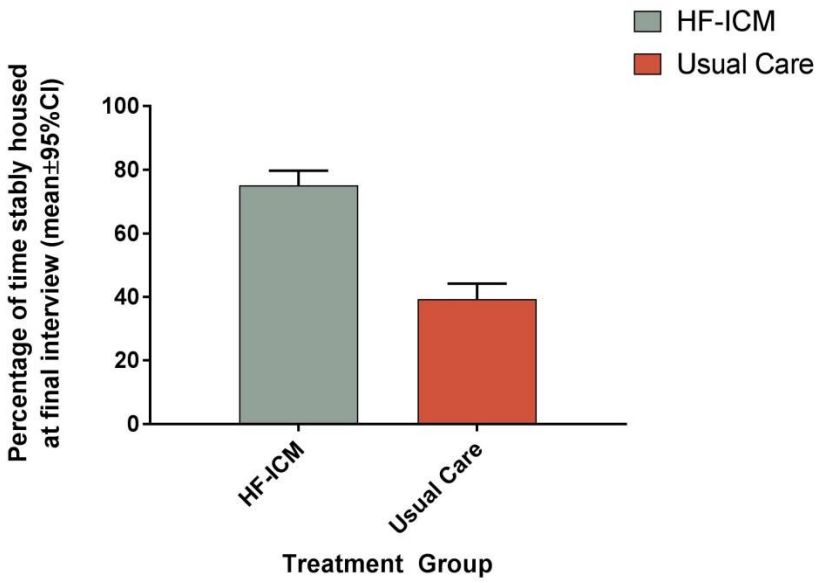
- Empowerment
- Education
- Building alliances
- Language
- Alternative healing strategies
- Advocacy, social justice/activism
- Fostering reflexivity

Corneau & Stergiopoulos, Transcultural Psychiatry, 2012

# Toronto Site Moderate Needs Participants

| Characteristics | HF-ICM (n=204) | Usual Care (n=174) |
|---|---|---|
| **Age, years, mean (SD)** | | |
| **Male** | 68% | 68% |
| **Single/never married** | 68% | 72% |
| **Member of racial/ethnic minority group** | 66% | 59% |
| **Longest period of homelessness, years, mean (SD)** | 2.50 ± 4.12 | 2.58 ± 3.61 |
| **Less than High School Education** | 51% | 43% |
| **MINI Diagnostic Categories** | | |
| **Depressive Episode** | 45% | 45% |
| **Post-Traumatic Stress Disorder** | 30% | 28% |
| **Panic Disorder** | 20% | 23% |
| **Psychotic Disorder** | 19% | 20% |
| **Substance Abuse or Dependence** | 71% | 75% |
| **Alochol abuse or dependence** | 38% | 43% |

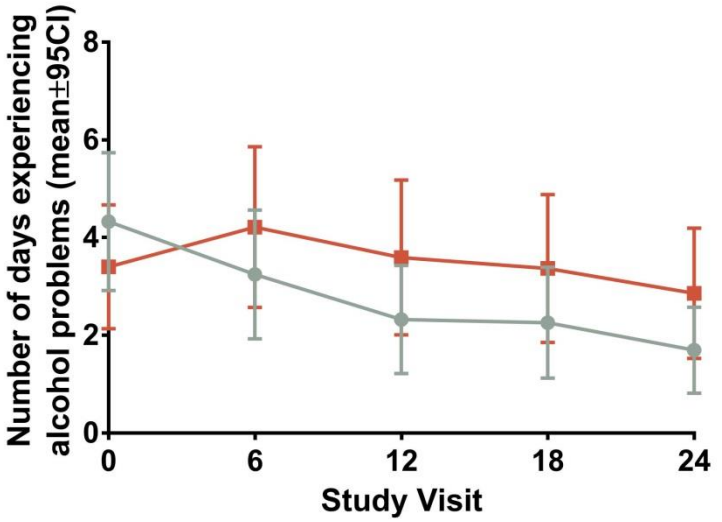
# Toronto Site HF-ICM vs. TAU: Housing & Hospitalization




- Fewer HF-ICM compared to TAU participants had ≥1 hospitalizations during this period (70.4% vs. 81.1%, respectively; P=0.044)
- Number of hospitalizations did not differ by treatment groups

Stergiopoulos et al., 2015 PLOS ONE

# Toronto Site HF-ICM vs. TAU: Alcohol use

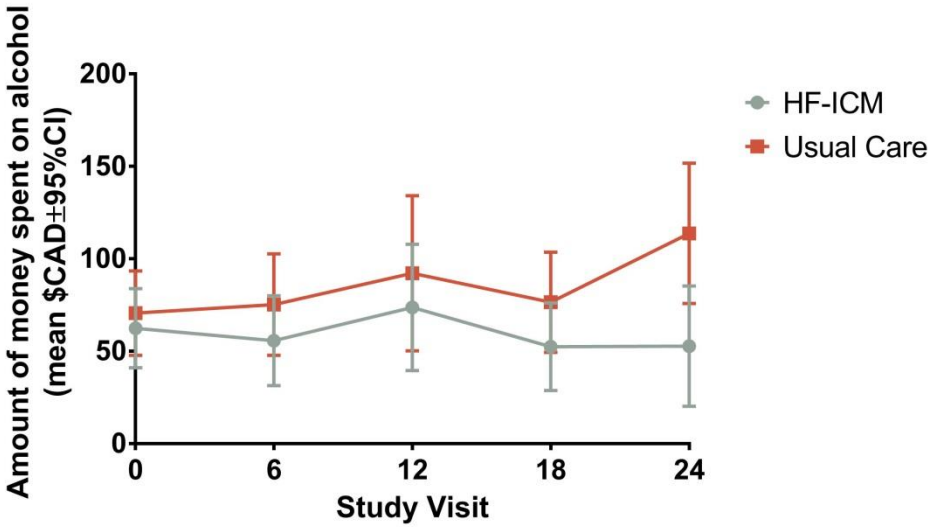



Ratio of rate ratio (24M/BL)

0.47 95%CI 0.22 to 0.99

This is a reduction of 53% from BL to 24M

Decreased $52.86 95% CI -104.29 to -1.43 (at 24M)



# Summary

Housing First can rapidly end homelessness among homeless adults with mental illness in diverse contexts in Canada, including racialized communities.

Housing First is a solid investment, and has become a policy direction provincially, and federally.

Despite improvements in housing, other recovery domains did no improve significantly over 24 months, compared to usual care.

# Sustainability

## Investing in Housing First

- The Ontario Government invested over $4M annually to sustain the Housing First teams in Toronto
- The Federal government invested over $600M to end chronic homelessness across Canada, endorsing Housing First.

## Delivering high fidelity Housing First

- Toronto was the only of 5 demonstration sites that continued to offer Housing First according to the evidence based model
- Concerns about program drift over time
- Concerns about lack of accountability for service user outcomes within existing service systems
- Inter-sectoral interventions not well supported within fragmented health and social care systems

# Next Steps

## Measuring long term HF outcomes

- Data collection of a one year continuation phase across sites completed
- Poor model fidelity may compromise  housing and health outcomes
- The Toronto site continues to collect longitudinal data, offering services of good model fidelity

## Housing First: What Next?

- Establishing a recovery College for people experiencing housing instability

# Housing First : What Next?

The Urban Angel Fund for Homeless People – a $10M endowment

Innovation incubator for homelessness and mental health

The innovation incubator's inaugural project – the STAR Learning Centre

**Canada's first recovery college**

# Students, not Patients

- Providing recovery-oriented services through emancipatory adult education, rather than through traditional health care services
- Strengths-based approach
- Courses provided in non-stigmatizing community settings to facilitate community integration
- Participant membership
- Professionals learn to share power, co-produce, co-deliver, co-learn

Chung et al, Intern J of Mental Health and Addictions, 2016

# Therapy vs. Adult Education

## Therapy

- Focuses on problems, deficits
- Strays beyond formal therapy sessions to become overarching paradigm
- Problems are defined, & solutions chosen, by the professional
- Maintains power imbalances

## Education

- Helps people recognize & use their talents & resources
- Explores possibilities & develops skills
- Supports personal goals & ambitions
- Staff as “coaches”

Perkins, Repper, Rinaldi & Brown (2012). Recovery Colleges. London: Centre for Mental Health.

# STAR Next Steps

Exploratory case study using realist approaches and mixed methods forthcoming

- Does it work, how does it work for whom does it work?
- What are the outcomes for individuals, organizations and the health system

International community of practice on recovery colleges

Fidelity tools, shared outcome measures

# Questions

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