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An Evaluation of the Impact of Rent Assistance on Individuals Experiencing Chronic Homelessness in Waterloo Region

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by

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Abstract

The main objective of this study was to examine the effectiveness of the addition of rent assistance to Waterloo Region's existing housing and support services. A quasi-experimental non-equivalent comparison group design was used to compare the outcomes between two groups: (a) participants selected to receive rent assistance plus intensive support services (n = 26) and (b) participants receiving support services only (n = 25). Participants were interviewed at baseline and again six months later. It was hypothesized that participants receiving rent assistance would show significantly greater improvement on housing outcomes compared to the comparison group, including greater number of days in stable housing and higher scores on perceived housing quality. It was also hypothesized that participants in the rent assistance condition would show greater improvements in: (a) quality of life, (b) social support, (c) community functioning, (d) food security, and (e) reduced use of hospital, emergency and justice services compared to participants not receiving rent assistance. In addition, qualitative interviews were conducted with a sub-sample of participants (n = 12) in order to answer the following research question: In what way does having access to rent assistance change participants' experiences of: (a) housing, (b) service use, (c) health and well-being, (d) relationships and social support, and (e) hopes for the future? A focus group was also conducted with the direct support workers (n = 10), which was guided by the research question: What are the direct support worker perspectives on the rent assistance program and what factors helped or hindered the implementation process? Mixed model ANOVAs were run in order to determine program outcomes. As hypothesized, participants receiving rent assistance showed significantly greater improvements in housing stability and quality of life than the comparison group. Perceived housing quality was also significantly higher among the rent assistance group, as

hypothesized. Participants in the rent assistance condition also showed significant improvements over time on measures of informal social support, community functioning, and food security compared to marginal improvements for the comparison group. However, the interactions between treatment and time were not statistically significant, thus providing only partial support for the hypothesis that rent assistance would improve other outcomes. Thematic analysis of the qualitative data found three life transitions that were initially identified in a larger pan-Canadian study on Housing First: (a) from street to home, (b) from home to community, and (c) from past to future. Participants receiving rent assistance were more likely to make these transitions than participants not receiving rent assistance and tended to describe more positive life experiences in housing, health and well-being, relationships and social support, and hopes for the future. The direct support worker focus group allowed for an examination of factors impacting the implementation of the rent assistance program. Findings from the focus group suggest that the addition of rent assistance empowers workers to be able to meet the housing needs of participants. However, there continued to be barriers as a result of program restrictions, landlord discrimination, and lack of affordable housing, highlighting a possible need for ongoing changes at the program, community, and societal level. Overall the findings demonstrate that rent assistance is a necessary component of any supported housing program, leading to superior housing stability, perceived housing quality, quality of life, informal social support, community functioning, and food security outcomes, and life transitions compared to participants receiving support services only. Thus, it is concluded that more funding be directed towards rent assistance in programs for people experiencing chronic homelessness across Canada.

Keywords: rent assistance, Housing First, program evaluation, chronic homelessness

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An Evaluation of the Impact of Rent Assistance on Individuals Experiencing Chronic Homelessness in Waterloo Region

Housing First (HF) is a supported housing model that provides permanent housing and individualized support services to people who are experiencing chronic homelessness and mental illness (Goering et al., 2014). The HF model has been shown to be an effective strategy in assisting individuals experiencing homelessness to find and retain housing and experience other positive outcomes, including improvements in mental health functioning, quality of life, and reductions in reliance on emergency services (Aubry, Nelson, & Tsemberis, 2015). For this reason, HF programs are being implemented in communities across Canada (Aubry, Tsemberis, et al., 2015; Gaetz, Gulliver, & Richter, 2014; Macnaughton, Nelson, & Goering, 2013). One important component of the HF model is rent assistance, as it provides participants with the means to afford housing, generating more choice and control over their living arrangement. Recently, the Region of Waterloo received funding for rent assistance that is currently being used to house 40 individuals experiencing chronic homelessness in the region. All those selected to receive rent assistance are connected to the Region's existing housing and support services – the STEP (Support to End Persistent Homelessness) Home program. Currently, the STEP Home program is undergoing change in order to become more aligned with a HF approach. The main objective of the research project is to examine the effectiveness of the addition of rent assistance to housing and support services compared to STEP Home services only in the Waterloo Region. The purpose is to build on existing HF literature and to inform best practices.

Literature Review

According to the 2014 *State of Homelessness in Canada* report (Gaetz et al., 2014), an estimated 235,000 individuals in Canada experience homelessness each year. On every night,

about 35,000 people do not have a place to go home to. Estimates of homelessness have been growing over the last two decades (Aubry, Farrell, Hwang, & Calhoun, 2013), partly as a result of cuts to social housing (Nelson, Goering, & Tsemberis, 2012). The 1980s marked the beginning of the federal government's withdrawal of financial investment in producing more affordable homes (Gaetz et al., 2014). Between 1982 and 2006, the number of new social housing units produced each year dropped from 20,450 to 4,393. Since the 1990s, the total federal government investment in social housing fell by 46% in spite of a 30% increase in Canada's population (Gaetz et al., 2014). Rates of homelessness have become so high that the issue is now considered to be a national crisis (Gaetz et al., 2014). In response to the seriousness of this matter, promises have been made by local politicians in communities across Canada to create socially sustainable solutions to the issue of homelessness and affordable housing (Gaetz et al., 2014; Macnaughton et al., 2013). This issue has been framed within the context of mental health as a result of evidence showing that rates of mental illness and addictions are higher among the homeless population (Folsom et al., 2005) and because of growing public awareness and concern of mental health issues in the community (Macnaughton, Nelson, & Goering, 2013) In order to address the complex issue of homelessness, a strong understanding of the root causes is needed.

Theoretical Framework

In the following section, ontological security and structuration theory, from Sociology, and ecological systems theory and empowerment theory, from Community Psychology, are introduced as complementary ways of understanding and overcoming homelessness.

Structuration theory and ontological security. Giddens introduced two useful concepts for understanding homelessness: structuration theory and ontological security.

Structuration theory (Giddens, 1984) speaks to the broader context within which certain social structures are produced, enabling issues of homelessness to arise. For instance, cuts to federal investment in social housing contributed to a decrease in affordable housing stock (Gaetz et al., 2014). Decisions to make funding cuts to social housing and other social welfare programs are guided by capitalist, neoliberal ideologies on which North American societies are structured. These ideologies are based on principles of self-reliance as opposed to reliance on the state, promoting competition for resources and contributing to systemic inequality (Nelson, 2013). These conditions render some people more likely to experience homelessness than others (Neale, 1997). For example, with fewer social housing options available, fewer people are able to afford the cost of housing, particularly among those who rely on social welfare for income. Individuals most likely to rely on income support are those who, due to existing societal structures, may be unable to obtain employment, such as people who may be struggling with complex health or mental health issues. As a result, individuals living with mental illness and/or addictions tend to be overrepresented in the homeless population (Folsom et al., 2005) and are more likely to experience long periods of homelessness (Kuhn & Culhane, 1998). From this perspective, homelessness emerges as a result of disempowering social structures.

Structuration theory also provides a framework for how to promote change. According to Giddens (1984), social structures consist of rules and resources. Rules are the social processes or norms that guide and orient behaviour. By following or adhering to the rules of the system, individuals play a role in reproducing this system and maintaining the status quo. Individuals and organizations can mobilize change by challenging these social processes as well as by putting political pressure on governments to increase their funding towards specific resources or calling for change in the way resources are allocated. According to Bernard et al. (2007), health

disparities are rooted in the unequal distribution of resources. The manner in which resources are distributed can be altered by considering rules of proximity, price, rights, and informal reciprocity. For example, we can promote access to housing by increasing the amount of housing available in a given community, by reducing the cost of housing, and/or by providing housing entitlements to those in need (Bernard et al., 2007).

Ontological security is another concept introduced by Giddens (1990) and that has been taken up in the context of HF. Ontological security is defined as: "the feeling of well-being that arises from a sense of constancy in one's social and material environment which, in turn, provides a secure platform for identity development and self-actualization" (Padgett, 2007, p. 2). According to Dupuis and Thorns (1998), four conditions must be met in order to establish a sense of ontological security: (a) control and self-determination, (b) routines of daily life, (c) freedom from supervision, and (d) identity construction. In other words, a home is a place where people are able to exert control over their environment, free from the watchful eyes of the outside world, leading to a sense of ontological security, opportunities for identity construction, and a greater sense of well-being (Padgett, 2007). By virtue of not having a stable home, individuals with a history of chronic homelessness experience less ontological security than those who have a place to go home too. Given that issues of health and mental illness are higher among the homeless population, having a secure home base may be particularly important among this group. The concept of ontological security provides a rationale for intervention models that prioritize stable independent housing as a way to promote recovery and well-being among individuals experiencing chronic homelessness.

Empowerment and ecology theory. Structuration theory provides a useful framework for understanding how the institution of social structures works to marginalize and disempower

certain groups in society. Empowerment theory holds that in order to address inequities that result from structural circumstances, change strategies should aim to empower those that have been pushed to the margins by directing resources to these groups and providing opportunities for self-determination and meaningful participation in the community (Rappaport, 1987).

Research has shown that a lack of consumer/service user involvement in decisions about one's health and housing contributes to a mismatch between services and individual needs and is associated with greater housing instability (Helfrich & Fogg, 2007) and a greater disengagement with the mental health system (Folsom et al., 2005). This finding demonstrates the importance of personal control and active involvement in matters that impact one's life. This emphasis on self-determination is at the core of empowerment theory. Rappaport (1987) characterizes empowerment as "individual determination over one's life and democratic participation in the life of one's community" (p. 1). He argues that empowerment is a multi-level construct and draws on Bronfenbrenner's (1992) ecological systems theory to understand the different levels at which empowerment can occur. An understanding of how each level is influenced by the other is needed in order to grasp how structural systems can be shifted to promote empowerment at the individual level. For example, as described in the previous section, systemic inequalities are produced as a result of societal alignment with a neoliberal capitalist agenda. Social transformative change is therefore required for the successful empowerment of individuals experiencing oppression.

Zimmerman (2000) further elaborates on Rappaport's (1987) notion of empowerment at the different ecological levels. He proposes that individual level empowerment is indicated by a person's sense of control, in addition to their critical awareness of and active involvement in shaping one's sociocultural and political environment (Zimmerman, 2000). Therefore, one way

to foster individual empowerment is through community organizations that provide opportunities for meaningful participation in decision-making activities. Zimmerman (2000) distinguishes between two types of organizations: (a) empower*ing* organizations that generate conditions for self-determination, and (b) empower*ed* organizations that impact policy and practice. Empowered communities consist of both types of organizations. They promote active involvement in the community and civic engagement among its citizens and are equipped with adequate resources that are equally accessed by all (Zimmerman, 2000).

Based on the above understanding of empowerment theory, the issue of homelessness requires change at the structural level (i.e., greater government support in terms of funding programs and social services), the community level (i.e., adequately resourced communities with opportunities for meaningful participation in civic matters), and the organizational level (i.e., the institution of social programs that promote choice and control over one's life). Empowerment at these various levels will lead to positive outcomes for the individual, including greater housing stability, quality of life, and community integration (Helfrich & Fogg, 2007). The present study can be understood within the context of each level. Structurally, recent financial support from the government has funded the implementation of a supported housing model. At the community level, the model has been designed to equip communities with the resources required to adequately meet the needs of those experiencing homelessness. Finally, individual empowerment is promoted via principles of choice and self-determination that are fostered at the organizational level. The positive outcomes we expect to see as a result of the implementation of HF in communities across Canada can be understood as the effect of multiple levels of empowerment. An ecological framework within the context of empowerment theory is used in the current study as a lens to understand the impacts of the research.

Implications for the research project. Because structural inequalities place fewer restraints on those with greater wealth and power, effective social change may require the collaborative effort of those who hold varying degrees of influence. This study aims to promote collaboration and address issues of power by creating a research team consisting of persons with lived experience, a graduate student, a professional researcher who is an expert in program evaluation and homelessness research, direct support workers, and representatives of the regional government. In the following review of the literature, HF is considered as an avenue for structural change and empowerment. In order to assess the potential impact of HF, research on program outcomes are considered. First, an analysis of the different types of homelessness is provided, followed by an introduction to HF and its principles. Finally, empirical research findings are presented, leading into a discussion on the role the current study plays in closing the research gap.

A Typology of Homelessness

Since cuts to social housing were made in the United States and Canada in the 1980s and 90s, new patterns of homelessness have emerged (Gaetz et al., 2014; Kuhn & Culhane, 1998). In particular, there has been a shift in the population characteristics of homelessness as a result of an increase in overall levels of poverty (Kuhn & Culhane, 1998). Many researchers argue that services should be tailored according to the needs of the different types of homelessness experienced (Aubry et al., 2013; Kuhn & Culhane, 1998; Nelson, Clarke, Febbraro, & Hatzipantelis, 2005). In order to identify what patterns of homelessness exist, Kuhn and Culhane (1998) examined public shelter usage data in New York and Philadelphia, between the years 1988-1995, and 1991-1995 respectively. The authors identified three main types of

homelessness based on number and length of stays in the shelter. The three types of homelessness include transitional, episodic, and chronic.

The transitional group refers to those who experience short-term homelessness, possibly as a result of some catastrophic event. Forty-nine percent of individuals belonging to this group reported experiencing a mental health and/or substance abuse issue and accounted for approximately 80% of the homeless population. Episodic shelter users tend to "shuttle in and out of homelessness" (Kuhn & Culhane, 1998, p. 211), and are likely to be younger in age compared to the transitional group. Sixty-six percent reported having a mental health and/or substance abuse issue. Chronic shelter users refer to those who have experienced longer stretches of homelessness. They often have serious and complex needs and tend to be much older in age compared to the other two groups (Kuhn & Culhane, 1998). Eighty-three percent of chronic shelter users reported experiencing a mental health and/or substance abuse issue. Although the transitional group accounted for the majority of the homeless population, those identified as chronically and episodically homeless accounted for the majority of shelter stays.

A study based in Ontario set out to investigate whether similar patterns of homelessness exist in Canada (Aubry et al., 2013). Shelter data were obtained from three Ontario cities, and three similar patterns of homelessness were identified: temporary, episodic, and long stay. Because of consistency in definitions, the terms transitional and temporary will be used interchangeably throughout this paper. The terms chronic and long stay will also be used to refer to the same group. Although long-stay shelter users only accounted for 2-4% of the population, they occupied more than 25% of the shelter beds in Ottawa and Guelph, and approximately 40% of beds in Toronto. Compared to the research results obtained by Kuhn and Culhane (1998), they found fewer people fell into the long stay category. The authors attributed this to an

increase in community mental health services in Ontario over the previous 10 years, including a homelessness initiative that allocated twenty million dollars to fund housing and support services in the late 1990s (Aubry et al., 2013; Kirkpatrick & Byrne, 2011).

The research conducted by Kuhn and Culhane (1998) and Aubry et al. (2013) illustrates that a small proportion of the homeless population expend the majority of shelter resources. Gladwell (2006) describes this configuration as a power-distribution where a small number of extreme cases have a big impact on the entire system. These findings suggest that policy and social service delivery should be directed towards those with the most complex needs. Individuals who fit into the transitional group may benefit the most from housing services that aim to facilitate transitions between jobs or housing. This group demonstrates less need for highly structured residential support since they generally demonstrate a capacity for independent living (Kuhn & Culhane, 1998). Although episodic and chronic shelter users account for a smaller proportion of the homeless population, they consume over half of total shelter days used (Aubry et al., 2013; Kuhn & Culhane, 1998). Therefore, these groups may benefit more from highly structured support services that aim to assist in long-term housing. This would lower the cost of emergency shelters and create more space for individuals experiencing transitional homelessness for which these services are intended. This approach is in line with empowerment theory as it aims to reduce structural inequalities by promoting access to resources among those who have been marginalized and disempowered. Targeting specific resources, such as housing and client-directed support services, increases opportunities for self-determination and is important for promoting a sense of ontological security. Given that chronic shelter users are more likely to be living in the most precarious living situations and experiencing complex mental

health and/or addictions issues, housing is needed in order to establish a secure base from which they can begin to move forward in their recovery.

The Housing First Approach

According to Gladwell (2006), an approach to service delivery that targets those who are most vulnerable is an example of power-law policy. Traditional housing and support services do not follow this approach. Instead, existing housing and support services in Canada and the United States tend to be based on a treatment-first model. Within the treatment-first approach, a person's access to housing is dependent on service provider evaluations of a person's sobriety, mental stability, and life skills, otherwise referred to as "housing readiness" (Dordick, 2002). This approach is based on the assumption that people who are homeless and who have complex needs do not have the capacity to maintain their own apartment. This orientation is disempowering as it takes a paternalistic approach to care and limits opportunities for self-determination (Nelson et al., 2012).

Nelson and colleagues (2012) advocate for the Pathways HF approach as an alternative to traditional models and challenge the assumption that people need to be "housing ready". Instead, Pathways HF argues that housing is a basic right and that people should be given immediate access to permanent independent housing regardless of their level of sobriety or mental health functioning. In order to promote immediate access to housing, a HF approach relies on the provision of rent assistance. Without rent assistance, participants are not able to afford the cost of housing, making it a critical component of the model. The Pathways HF approach aims to empower participants by adhering to an additional five core principles: (a) consumer-driven services, (b) separation of housing and clinical support, (c) recovery orientation, (d) a harm reduction approach, and (e) community integration (Nelson et al., 2012). That is, housing and

support services are based on principles of self-determination whereby individuals receiving Pathways HF are able to choose where they want to live and what types of services they want to receive. Furthermore, housing is not dependent on a person's level of sobriety, moving away from moral based approaches that often rely on punishment to deter participants from engaging in "bad behaviour" (Collins et al., 2012). By taking a harm reduction approach, the negative impacts of substance use are minimized, and participants are provided with information and resources that allow them to make their own informed decisions. Individualized supports are also kept separate from a person's housing so that they are able to establish a sense of home and to ensure that a person's network of support is not severed as a result of moving or eviction. Because of the potential impact for community integration and quality of life, proponents of Pathways HF also believe in helping people to access normalized, market housing, as opposed to social housing such as group or transitional homes (Nelson, 2010). Finally, Pathways HF has adopted a recovery orientation, which challenges the assumption that psychiatric illness is a life-long degenerative disease (Nelson et al., 2012). Proponents of the program believe that recovery is not only possible but also probable, particularly when hope is fostered through conditions of support and empowerment (Nelson et al., 2012). In other words, with the appropriate support and structural conditions in place, people are empowered to exercise their agency and reclaim their lives.

By taking into account structural factors (i.e., greater government involvement in supporting opportunities for independent living), community level factors (i.e. opportunities for community integration), program level factors (i.e. opportunities to access housing and support services) and individual agency (i.e., greater choice and personal control as a result of client-directed support), this approach to recovery considers structural circumstances that enable

homelessness and is in line with an ecological/empowerment approach. By creating opportunities for choice in housing and control over the types of support services one receives, HF fits within the definition of an empowering organization through which individual level empowerment is achieved. However, empowerment at each of these levels is contingent on participants' access to rent assistance. Without this component, choice and control over one's housing is not possible, reducing the likelihood that a person's needs are met, and that the individual will retain her or his housing (Helfrich & Fogg, 2007).

The following section provides a summary of the findings on supported housing and HF as one exemplar of a supported housing approach.

Research on Outcomes of Housing First

Reviews. Aubry, Ecker, and Jette (2014) provided a review of outcome research on supported housing compared to other housing models. Support*ed* housing, such as HF, is typically compared to support*ive* housing. Supported housing refers to programs that combine permanent housing and support services based on consumer preferences. Typically, people receiving supported housing move into independent living right away and are provided with rent assistance such that they pay no more than 30% of their income on rent. Permanent independent living is provided in conjunction with individually tailored support services that are kept separate from housing. In comparison, supportive housing aims to promote independence via on-site treatment and rehabilitative services. Supportive housing is based on a continuum model of care through which residents are expected to move from more restrictive into less restrictive settings as a result of demonstrated improvements in community functioning and mental health (Nelson, 2010). Researchers have found that supported housing is more in line with consumer preferences than any other program (Aubry et al., 2014; Rog et al., 2014). By matching program

services with consumer preferences, self-determination is promoted, including the participants' ability to choose the services that are right for them. This is an example of an empowerment theory model. A preference for permanent independent living suggests that having a secure home base is important for participants experiencing chronic homelessness, as indicated by Giddens' concept of ontological security.

Program model overlap, in addition to inconsistencies in the way researchers and community organizations define supported housing, make it difficult to draw conclusions about the program (Aubry et al., 2014). In the time period captured by Aubry et al.'s (2014) review, widely accepted criteria defining supported housing had not yet been established and there was no way to assess fidelity. Nine studies in total were included in the review. In order to be included in their review, studies had to: (a) be published in a refereed journal, (b) compare at least two groups, one of which had to be a supported housing program, and (c) employ quantitative measures to evaluate program effectiveness. Based on their review, the authors concluded that supported housing did not show better outcomes in terms of reducing psychiatric symptoms, substance use, or community adaptation compared to other models. On the other hand, the supported housing model had positive outcomes including increased housing stability, improved quality of life, and reduced emergency service use. However, these findings were similar to those associated with standard care (Aubry et al., 2014). A clearer definition of supported housing in addition to methods for assessing fidelity were needed in order to make stronger conclusions about the effectiveness of the program (Aubry et al., 2014).

Rog and colleagues (2014) also conducted a review of the literature in order to assess the impact of permanent supportive housing (i.e., programs combining individualized support with permanent independent living). Studies included in the review had to: (a) be published between

1995 and 2012, (b) be printed in English, (c) employ a randomized controlled trial (RCT) or quasi-experimental design (review articles were also included), (d) consist of individuals diagnosed with a mental illness and/or substance use disorder, and (e) evaluate programs that met criteria for permanent supportive housing. Eight review and 12 individual studies met the inclusion criteria. Based on their review, programs combining individualized supports with permanent independent living led to increased housing stability in addition to reductions in homelessness and the use of emergency services. However, the authors found that the majority of studies included in this review had small samples and considerable variability in terms of comparison groups and outcome measures, making the task of drawing cross-study comparisons even more difficult (Rog et al., 2014). A controlled comparative study that provides a systematic evaluation of outcome measures across the range of permanent supportive housing programs would help to determine which programs are most effective for who.

Several outcome domains have been examined in research on supported housing, including: (a) service utilization, (b) housing stability, and (c) recovery trajectories based on qualitative interviews. A summary of the research findings for each of these domains is provided below.

Service utilization. One finding is the impact of supported housing on service utilization. In their study on the impact of supported housing for intensive users of hospitals and addictions services, Srebnik, Connor, and Sylla (2013) examined reductions in service use between participants in a HF program compared to those relying on existing services in the community. Participants in each group did not differ in terms of service utilization prior to entry into the study. However, HF participants dropped 74% in terms of emergency department use and inpatient admissions compared to a 26% and 48% drop for the comparison group. The

authors also found a 93% drop in use of addiction services for participants receiving HF compared to a 26% drop for the comparison group. Jail use did not change significantly between baseline and follow-up for either of the study groups. Additional reviews of the HF literature have found similar impacts on service utilization (Nelson, Aubry, & Lafrance, 2007; Rog et al., 2014). This impact on emergency service use is an example of the economic benefits of implementing an intervention that is based on a power-law policy (i.e., targeting resources to chronic service users). By ensuring that participant needs are met through housing and intensive support services, there is less strain on emergency and crisis support services, providing economic justification for the implementation of supported housing models.

Housing stability. The most consistent finding in this literature is the relationship between supported housing and housing stability. Reviews of the literature on the effectiveness of supported housing for people with a history of homelessness and mental illness found that participants receiving some level of permanent housing and support were significantly more likely to achieve housing stability compared to standard treatment (Aubry et al., 2014; Benston, 2015; Nelson et al., 2007; Rog et al., 2014). Those receiving rent assistance had better housing outcomes, particularly in terms of quality of housing, housing choice, and housing problems compared to standard treatment, case management alone, or residential treatment (Nelson et al., 2007). They also tended to experience greater involvement in community programs. Interventions that combined rent assistance and case management were also more positively related to increased social networks and perceived quality of life (Nelson et al., 2007).

Recovery findings. A number of qualitative studies have also found stable housing and individualized supports to be important ingredients for promoting recovery. In particular, having one's own home was associated with a sense of control over one's life and an increased sense of

security and privacy, markers of ontological security (Padgett, 2007). Stable independent housing was also associated with more opportunities for establishing supportive relationships with case workers and family, increased connectedness to one's culture and traditions, and greater involvement in meaningful activities including taking on new and valued social roles (Kirkpatrick & Byrne, 2011; Nelson, Clarke, Febbraro, & Hatzipantelis. 2005; Nelson et al., 2015). These findings suggest that ontological security plays an important role in mediating the relationship between housing and well-being.

In an effort to synthesize published qualitative results on the experiences of individuals living with serious mental illness in finding and securing a home, Gonzalez and Andvig (2015) performed a systematic review and identified several themes within the literature. The first of these are: (a) the Transition to a Home and (b) the Having and Estating of a Home. These themes capture the experience of relief from stressors associated with living on the street and a general improvement in quality of life, feeling safe and secure, having a sense of privacy and home base to perform daily tasks and self-care, and a feeling of autonomy and control over one's living arrangements. These experiences mirror some of the conditions necessary for establishing a sense of ontological security (Dupuis & Thorns, 1998). The next two themes include: (c) Home – the Mental Health Hub and (d) Home – the Base Camp for Reconnecting and Relating. These themes capture a feeling of uncertainty about what to do next experienced by some participants after they have been housed. For many participants, their vision for the future is hopeful and they are able to reconnect with family and repair social roles. However, for some, their vision for the future is influenced by feelings of loneliness and isolation as well as feelings of rejection and family burden.

Research conducted by Padgett and colleagues (2016) highlighted close relationships and meaningful activities as factors most likely to lead to positive change among participants enrolled in a supportive housing program, however, these domains also negatively impacted recovery when they declined. The researchers took these findings to suggest that meeting basic needs, such as housing, is not sufficient in and of itself to lead to recovery. Opportunities to build relationships and adopt meaningful roles in the community are critical. Lastly, findings from another qualitative study conducted by Padgett, Stanhope, Henwood, and Stefancic (2011) provide corroborating evidence related to substance use and show that participants receiving HF services were also less likely to use substances, to access substance use treatment services, and were less likely to drop out of the housing program compared to their treatment-first counterparts.

The articles included in the above review present strong support for a supported housing approach for individuals experiencing chronic homelessness and mental illness. The effectiveness of HF interventions may be due to increased opportunities for empowerment, self-determination and an improved sense of ontological security. Benston (2015) notes, however, that the bulk of published studies on supported housing are characterized by several limitations including: attrition, selection bias, response bias, unclear definitions and implementation of housing programs, lack of appropriate controls, and lack of fidelity of housing programs. She argues that these limitations make it difficult for policymakers to make informed decisions about the best approach to address issues of chronic homelessness. A need for more rigorous research that is conducted within a Canadian context is emphasized.

Accumulated evidence on HF programs, in addition to growing awareness of the issue of homelessness in Canada, led to the funding of a national research demonstration project that

aimed to evaluate the effectiveness of the HF model in five major Canadian cities: the At Home/Chez Soi (AHCS) Research Demonstration Project (Goering et al., 2014). Evidence directly stemming from this project is described in the following section.

At Home/Chez Soi Research Demonstration Project

The AHCS research demonstration project evaluated the effectiveness of HF programs compared to treatment as usual across five major Canadian cities: Vancouver, Winnipeg, Toronto, Montreal, and Moncton. The HF programs evaluated in the At-Home study were combined with two types of support services: (a) Assertive Community Treatment (ACT) for individuals with high needs, and (b) Intensive Case Management (ICM) for individuals with moderate needs. ACT consists of services provided by a multidisciplinary team, whereas, ICM consists of individual case management (Macnaughton, Nelson, & Goering, 2013). Quantitative interviews were conducted every six months over a period of two years and included instruments measuring quality of life, service use, housing history, and community functioning. Qualitative interviews were also conducted with a sub-sample of study participants in order to provide complementary data to quantitative research findings (Goering et al., 2014). In order to obtain strong evidence of the impact of HF programs in Canada, fidelity assessments of the HF programs were conducted. An assessment of fidelity helps to ensure that the researchers are able to determine which program components account for which outcomes (Nelson et al., 2014). A two-year report on the findings from the AHCS study found that participants in both the HF and TAU conditions had similar improvements in health, mental health, and substance use issues (Goering et al., 2014). Other findings are consistent with previous results and fit within the three main domains described in the previous section (Aubry, Tsemberis, et al, 2015; Goering et al., 2014; Nelson et al., 2012). A summary of the results is provided below.

Service utilization. The At Home project found that within the first six months of receiving HF services, there were significant reductions in emergency room visits for HF participants, relative to TAU participants in both the high needs and moderate needs groups (Aubry, et al., 2016; Stergiopoulos et al., 2015). However, significant reductions were not observed at the 24-month follow-up and were similar for HF and TAU participants in both the high needs and moderate needs groups (Aubry et al., 2016; Stergiopoulos et al., 2016). Mixed findings on service utilization may be due to differences in the Canadian healthcare system compared to the United States. Participants in AHCS would have had access to universal healthcare services regardless of which study condition they were assigned to. This is unlikely to be the case among those who participated in HF research in the United States where healthcare is much less accessible (Aubry et al., 2016). Based on a cost savings analysis of the results, HF saved the Canadian economy on average $21,375 per person with high needs and $4,849 for those with moderate needs (Goering et al., 2014), that is 96% of what it costs to implement a HF program for those with high needs (Aubry et al., 2016) and 34% of what it costs to implement a HF program for those with moderate needs (Stergiopoulos et al., 2015). The cost-effectiveness of the HF model provides justification for implementing a power-law policy. In addition to providing opportunities of empowerment among a highly marginalized group, targeting services to those with the most complex needs leads to greater economic savings. This provides incentive for the federal government to invest in widespread implementation of the program, and it also frees up emergency services so that service providers are better equipped to support those who are experiencing acute crises and/or transitional homelessness.

Housing stability. Consistent with preliminary studies investigating the effectiveness of supported housing, the impact of HF on housing stability and quality of life was substantiated in

the At Home study. The researchers found that 73% of HF and ACT high needs participants compared to 31% of high needs participants receiving TAU were living in stable housing one year after entry into the program (Aubry, Tsemberis, et al., 2015; Aubry et al, 2016). Similar results were found for participants with moderate needs receiving ICM (Stergiopoulos et al., 2015). An analysis of the two-year results found HF participants to have spent an average of 71% of their time over the 24-month period in stable housing compared to 29% for TAU. HF participants also moved into housing more quickly than TAU (Aubry et al., 2016).

While HF participants showed greater and more rapid improvements in quality of life and community functioning within the first 12 months of the study (Aubry, Tsemberis, et al., 2015; Goering et al., 2014), TAU participants showed continued improvements over time, narrowing the gap by the end of the two year study period (Aubry, Tsemberis, et al., 2015; Aubry et al., 2016). In terms of housing quality, HF participants experienced greater gains than TAU. However, this varied across sites with the greatest gains seen for Vancouver and Moncton HF participants and no differences between groups in Montreal (Aubry et al., 2016). With respect to quality of life, improvements in safety, leisure, living situation, and total quality of life score remained significant for HF participants over the course of the two-year study period. Based on these findings, the authors conclude that HF is an effective program for assisting individuals experiencing homelessness and severe mental illness find and retain permanent housing compared to those relying on standard treatment and services, providing evidence for interventions that are based on an empowerment model (Aubry, Tsemberis, et al., 2015).

Recovery findings. In order to gain a deeper understanding of underlining mechanisms associated with life changes in the At Home study, a qualitative component was incorporated as part of the research. In particular, the researchers examined the impact of HF on psychosocial

outcomes, including factors related to recovery and community integration (Nelson et al., 2015). Qualitative interviews with participants receiving HF or TAU services over a period of 18 months indicate that HF participants are twice as likely to experience positive changes compared to their TAU counterparts; whereas TAU participants were four times as likely to experience negative changes. Factors related to positive changes include a sense of hope acquired through housing stability, social support and connectedness to one's culture, and opportunities to adopt new, meaningful roles in the community (Nelson et al., 2015).

Factors associated with negative life changes after entry into a housing program include housing instability, isolation, and negative social contacts. Participants receiving standard care tended to report negative life changes as a result of adverse social contacts, whereas negative life changes among HF participants tended to be associated with social isolation. Other factors related to negative or mixed life changes include relapse or ongoing heavy substance use, feelings of hopelessness, and perceived failure (Nelson et al., 2015).

In another analysis of the qualitative findings from the At Home project, Macnaughton et al. (2016) set out to compare the recovery journeys of study participants. Participant journeys were characterized by three life changes, transitions from: (a) street to home, (b) home to community, and (c) present to future. Several factors made it difficult for participants to make transitions, including feeling a lack of purpose once housed, a need for more support related to school and employment, maintaining negative social networks, and isolation. Developing a sense of belonging in the community also took time for many participants (Macnaughton et al., 2016). These themes of life transitions were more prominent for HF than TAU participants, suggesting that having a secure home base made it possible to become more fully integrated into the community and orient oneself towards the future.

Overall, research studies indicate that HF may be an effective channel through which oppressive societal structures that perpetuate homelessness are challenged. By demonstrating cost-effectiveness, proponents of HF are able to solicit financial support from the federal government, funnel it towards supported housing, and effectively move people off the street and into their own homes. The HF model also challenges traditional forms of housing that are based on a paternalistic model of care, where service providers impose program regulations "in the name of the client's own good" (Willse, 2010, p. 166). Instead, proponents of HF argue in support of individual rights to self-determination. In line with structuration theory, proponents of HF recognize the role that social structures play in marginalizing particular groups of individuals (i.e., those with complex health and mental health needs), and aim to address these inequalities by advocating for greater federal investment in supported housing programs. By advocating for more resources to help facilitate the implementation of supported housing programs, HF also supports empowerment at the organizational level (i.e., community organizations are adequately resourced to meet the needs of participants) and individual level (i.e., participants are empowered to make decisions about their housing and support needs), contributing to empowerment at the community level (i.e., communities are made up of empowering organizations that facilitate greater participation and civic engagement among a larger number of it's citizens). The HF approach is therefore aligned with an ecological empowerment theory.

Rent Assistance

This research is one of few studies that look at the impact of rent assistance compared to case management alone for individuals experiencing chronic homelessness. The two studies that do exist were conducted in the United States. Among these are an evaluation of the McKinney

Research Demonstration project and of the US Department of Housing and Urban Development (HUD) and the US Department of Veterans Affairs Supported Housing (HUD-VASH) Program.

The McKinney Research Demonstration project is an evaluation of the impact of rent assistance on housing outcomes for individuals experiencing chronic homelessness and living with mental illness in San Diego (Hurlburt, Wood & Hough, 1996). Three hundred and sixty-two participants were randomly assigned to one of the four following conditions: (a) rent assistance plus comprehensive case management, (b) rent assistance plus traditional case management, (c) comprehensive case management only, and (d) traditional case management only. Participants receiving rent assistance were more likely than those without rent assistance to achieve stable independent housing. More than a quarter of participants who did not receive rent assistance were not able to access stable independent housing over the two-year study period. Those who were able to achieve stable housing in the community were either living with a friend or family member, in a boarding home, or halfway house.

HUD-VASH is another supported housing program that combines intensive case management with rent assistance for veterans experiencing chronic homelessness. The original evaluation of the HUD-VASH program randomly assigned 460 veterans experiencing homelessness and who had a mental health or substance dependence diagnosis to one of three conditions: (a) HUD-VASH - intensive case management plus rent assistance (n = 182); (b) case management only (n = 90); and (c) standard care (n = 188) (Rosenheck, Kasprow, Frisman, & Liu-Mares, 2003). The researchers found that HUD-VASH participants had better housing outcomes than participants in either of the comparison groups. They spent on average 16% more days in stable housing than case management alone and 25% more days in stable housing than those receiving standard care. They also spent, on average, about 35% fewer days on the street

than either of the two groups. No differences were found in mental health and community functioning. The researchers determined that the positive impact of the HUD-VASH program far outweighed the cost, which was approximately 15% more than the cost of standard care.

Using data collected from an evaluation of the HUD-VASH program, Tsai, Kasprow and Rosenheck (2011) examined whether employment earnings and clinical outcomes were associated with housing success. They evaluated the outcomes of four different groups, participants that were: (a) housed in their own apartment without a voucher (n = 96); (b) housed in their own apartment with a voucher (n = 93); (c) housed in another individual's place (n = 60); or (d) not housed at all (n = 170). The researchers found that participants housed *with* rent assistance had greater housing satisfaction and better quality of life outcomes in terms of their living situation and feelings of safety than all other groups (Tsai, Kasprow & Rosenheck, 2011). Participants who were housed *without* rent assistance often lived in shared housing. They also reported having significantly lower positive and higher negative housing characteristics than those housed with rent assistance. Regardless of whether or not a participant received rent assistance, those who were independently housed had greater life satisfaction than those who continue to be un-housed, providing further evidence that housing is an important component of any community-based intervention aiming to address issues of chronic homelessness.

Additionally, this re-evaluation of the initial findings of the HUD-VASH program found participants receiving rent assistance plus intensive case management to have substantially fewer days of alcohol use, drinking to intoxication, and drug use as well as less money spent on alcohol and drugs than participants receiving standard care. The re-analysis also found that the rent assistance plus case management group had fewer days of intoxication than case management only groups. These differences may not have been accounted for in the original analysis because

those participants with more days of intoxication may have been more likely to miss their follow-up interviews (Cheng, Lin, Kasprow & Rosenheck, 2007).

In Nelson et al.'s (2007) literature review on the effectiveness of supported housing, ACT, or ICM interventions for people with a history of homelessness and mental illness, participants who had access to housing (by means of rent assistance) plus support were reported to have better housing stability outcomes than those receiving either ACT services or ICM services alone. This review further emphasizes the importance of permanent independent housing as a component to interventions that aim to address issues of chronic homelessness.

In summary, many participants who do not have access to rent assistance are still able to secure stable housing (Hurlburt et al., 1996). Those housed without rent assistance reported more negative housing characteristics (Tsai et al., 2011), and tended to live in shared housing situations (Hurlburt et al., 1996), suggesting that their overall quality of housing was lower than those housed with rent assistance. The findings also suggest that access to a combination of rent assistance and intensive support can have a greater impact on housing stability (Nelson et al., 2007; Rosenheck et al., 2003), quality of life (Tsai et al., 2011), and substance use outcomes (Cheng et al., 2007) than case management programs alone. These findings highlight the critical role that rent assistance plays in helping participants establish a sense of ontological security by means of accessing and securing stable independent housing, leading to improvements in quality of life and recovery. The present study will contribute to the limited research in this area by conducting a similar evaluation within a Canadian context.

Research Objectives

By conducting an evaluation of the HAWS (Housing Assistance with Support) rent assistance program in Waterloo region, my advisor and I hope to make an impact locally as well

as contribute more broadly to the implementation of HF programs across Canada. We hope that outcomes of the research will be used to promote a more effective housing and support system for people who are chronically homeless based on research evidence and values of empowerment, recovery, community integration, and social justice. Some important areas for further research include more studies conducted in different Canadian contexts (Benston, 2015) and with various subpopulations to determine which intervention components work for which subgroups (Nelson et al., 2007). There is also a need for greater consistency in terms of outcome measures used in research (Benston, 2015), longitudinal studies that investigate long-term outcomes (Nelson et al., 2007; Rog et al., 2014), and studies that investigate ways to promote social integration once housing stability has been achieved (MacNaughton et al., 2016; Nelson et al., 2015). This research aims to address some of these shortcomings. For one, by implementing a HF program in the Waterloo region, knowledge on the effectiveness of HF within a new Canadian context is gained. Second, by specifically investigating the effectiveness of the addition of rent assistance to Waterloo Region's STEP Home services, the research study contributes to knowledge on the impact of individual components of the HF model. Third, by employing a similar research protocol to the one used in the At Home study, there is greater consistency in terms of outcome measures allowing for cross-study comparison. Finally, through qualitative analysis of consumer narratives and a direct support worker focus group, the current study contributes to an understanding of factors associated with life changes as well as barriers and facilitators to program implementation.

Hypotheses and Research Questions

Primary quantitative hypotheses. Based on the results that have been summarized in the above literature review, my advisor and I hypothesized that participants receiving HAWS

would show significantly greater improvements on housing outcomes compared to those receiving treatment as usual. In particular, HAWS participants would show greater number of days in stable housing and fewer days in shelters or on the street, as well as higher scores on the perceived housing quality scale, compared with non-HAWS participants.

Secondary quantitative hypotheses. My advisor and I predicted that participants receiving HAWS would also show greater improvements in: (a) quality of life, (b) informal social support, (c) community functioning, (d) food security, and (e) reduced use of hospital, emergency, and justice services compared to non-HAWS participants as a result of experiencing individual level empowerment and a greater sense of ontological security. The instruments selected to measure outcome variables were drawn from the At Home study in order to facilitate cross-study comparisons.

Recovery research. Informed by prior research on consumer narratives of HF service recipients, qualitative interviews were included as part of the follow-up interview process for a sub-sample of participants. The qualitative component of the research was guided by the following research question: In what way does having access to HAWS change participants' experiences of the following five life domains: (a) housing, (b) service use (i.e., STEP Home support), (c) health and well-being, (d) relationships and social support, and (e) hopes for the future? Qualitative findings provide complementary data on the impact of the rent assistance program as they relate to empowerment theory and ontological security.

Implementation research. A focus group was conducted with STEP Home direct support workers in order to gain a greater understanding of the implementation process. The focus group was guided by the following research question: What are the direct support worker perspectives on the rent assistance program and what factors helped or hindered the

implementation process? Findings will contribute to knowledge related to empowerment at the program, community, and systems level.

Methodology

Research Paradigm

Grounded in the belief that paradigms are not incompatible but rather complementary to one another (Nelson & Prilleltensky, 2010), the proposed research project is aligned with the following two paradigms: (a) critical transformative and (b) post-positivist.

Critical transformative paradigm. A critical transformative paradigm has as its main objective the liberation of oppressed groups (Nelson & Prilleltensky, 2010). Researchers working from within this paradigm believe that reality is constructed by societal structures and that systems change is the key to addressing issues of social injustice. Homelessness is an example of a social problem that has been produced as a result of structural inequalities and, according to this paradigm, must be addressed via macro-level change. At the heart of the critical transformative paradigm are values of self-determination, inclusion, and researcher accountability to marginalized groups (Nelson & Prilleltensky, 2010). These values are consistent with the one's that I hold and were used to guide the research process.

Methodologically, researchers working from within the critical transformative paradigm take a participatory action approach, where collaboration with communities is given prominence. My advisor and I worked collaboratively with various community partners including the Region of Waterloo, STEP Home, and the Kitchener Downtown Community Health Centre (KDCHC) in order to develop a research project that is suited to the local context. KDCHC also hired three peer interviewers with lived experiences to be a part of the research team. The peer interviewer role was critical to shaping a research protocol that is sensitive to the needs of the community

and target population. It was also an opportunity for capacity building as the peer interviewers are provided with an opportunity to gain valuable research experience.

With regard to the study's critical transformative potential, the proposed research project is part of a broader social movement that has set out to challenge the existing housing support system. Traditional mental health housing and support services are based on a treatment-first model that requires consumers to demonstrate their "housing readiness," including a commitment to sobriety (Nelson & Prilleltensky, 2010). This disempowering approach to service delivery assumes that individuals experiencing mental illness and/or homelessness do not have the capacity to retain housing or make decisions for themselves. The HF movement is advocating for systems level change, including a redirection of services that will make more efficient use of existing resources and create opportunities for empowerment, including greater choice and control over one's housing and the services one receives. These objectives are consistent with values of self-determination, inclusion, and researcher accountability, strengthening the project's fit within the critical transformative paradigm.

Post-positivist paradigm. One underlying assumption of the post-positivist paradigm is the belief that one "can use research findings to advocate for social change" (Nelson & Prilleltensky, 2010, p. 260). By building on the existing HF literature, my advisor and I hope to gather more evidence to support the implementation of HF services across Canada. Although post-positivists are guarded apropos what can be known of reality, there is an ontological commitment to the belief that an external reality does indeed exist (Nelson & Prilleltensky, 2010). As a result, measures are taken in order to control for factors that may distort results, such as extraneous variables or researcher bias. In line with this approach, the proposed project is predominantly quantitative in nature, and intends to employ psychometric instruments that

have been tested for validity and reliability (Nelson & Prilleltensky, 2010). Each scale will be used to measure a separate construct, and findings will be triangulated through the use of mixed methods (i.e., open-ended questions will be posed as part of the follow-up interview process). A post-positivist approach is a good fit for this study because of the ease in which both quantitative and qualitative data can be communicated to policymakers. Moreover, a post-positivist approach is consistent with previous HF research, which will facilitate cross-study comparisons.

Personal Reflexivity

My knowledge of community mental health is based in part on my experiences as a mental health support worker. Through my work, I have witnessed the harmful effects of social inequality and the power struggles that exist at the various levels of the mental health system. As a support worker, one often becomes a sounding board against which people express their anger at a system that does not adequately meet their needs. Although on an individual level, I had the opportunity to develop strong connections with the people I supported, I did not feel that I was able to provide what was really needed, including a more efficient and integrated service delivery system and greater self-determination among mental health consumers. The personal struggles I experienced in my work led to my dissatisfaction with the existing system, and provided me with incentive to return to school. I hoped that through the education system, I would gain valuable knowledge and skills that could be used to create the change that I believe is required to adequately support individuals experiencing homelessness and mental illness.

My experiences as a support worker also helped to shape the values that I carry with me in my work, and in life. These values include a respect for all persons; including one's right to be treated with dignity and to be included in decisions that impact one's self. I am also motivated by values of social justice, and believe that housing is a basic right that should be

afforded to everyone. In order to create change and make equal access to housing a reality, I believe research and empirical grounding is a necessary tool. It is through the accumulation of evidence that a case can be developed that will convince those in power of the merit of change. Finally, I believe in the importance of collaboration; in particular, working together with communities to ensure that all voices are heard and that local needs are met. The values I have described here underlie the various aspects of this research.

My experience conducting the research was met with both challenges and successes. One notable challenge at the start of the project related to obtaining "buy-in" from the direct support workers. The decision to go forward with an evaluation of the rent assistance program was made by the Region of Waterloo and was therefore "top-down." There was noticeable resistance against the research from the workers, with expressed concern of exploitation and skepticism regarding our ability to grasp the unique values and characteristics of the STEP Home program. As the project continued, I became more aware of the delicate line that I was traversing between the regional government, front-line staff, participants and the peer researchers. The research project also came at a time of change, where conversations about reshaping existing services were just beginning. It was clear that the rent assistance project was wrapped up in these changes, and that different people had different ideas about whether the implications were positive or negative. It was strange to feel like an outsider whose intentions were questioned. Regardless of these difficulties, I strongly believed in the value of working with this community and in the importance of building evidence for the implementation of supported housing programs. In order to address the tensions that existed at the start between the direct support workers and my advisor and me, we offered to meet with the workers informally to answer any questions. This led to an engaging conversation resulting in the decision to incorporate a direct

support worker focus group. From that point on, I began working very closely with the different agencies, and had the opportunity to build positive relationships with the workers over time.

The opportunity to work with peer researchers aided in the process of becoming more integrated into the community. Each peer researcher had prior experience volunteering and working with the different agencies which helped me to develop a better understanding of the community and their approach to service delivery. The peer researchers often acted as a bridge between the workers, the participants, and myself. At the same time, working with peer researchers was another domain that I needed to learn to navigate. There were challenges related to accommodating schedules, establishing consistency in data collection, and differences in working style and needs for support. The interviews were sometimes "triggering" for the peer researchers, and issues related to mental health arose over the course of the research project. The project took place over a two-year period, over which time the peer researchers took on new roles and had less time to dedicate to the project. By mid-way of the second year, I was completing interviews on my own. This posed separate challenges as locating participants who were not housed required creativity, flexibility, and perseverance.

My commitment to delivering an end result that could have important implications for the community provided personal motivation as different obstacles presented themselves over the course of the study period. The successful outcomes of this project reaffirmed my experiences and the value and importance of working with communities to conduct research.

Research Context

This study took place in Waterloo region, located in southwestern Ontario. Waterloo region is the tenth largest urban area in Canada and consists of the following urban municipalities: Kitchener, Cambridge, and Waterloo, in addition to the townships of Wellesley,

Woolwich, Wilmot, and North Dumfries. The Region of Waterloo provides public health and social services in each of these urban areas (Region of Waterloo, 2010). At the end of 2015, the population of Waterloo region was estimated to be 575,000 (Region of Waterloo, n.d.), with, approximately 3,492 individuals experiencing homelessness as of 2013 (Region of Waterloo, 2013), and 2,719 on a waitlist to receive housing as of 2014 (Homeless Hub, n.d.).

The Region of Waterloo's Housing Services division is dedicated to the empowerment and improved quality of life of individuals experiencing homelessness. In collaboration with 12 community agencies, the Region of Waterloo and STEP Home provide an integrated network of support services and housing opportunities (Region of Waterloo, 2014b). STEP Home is a value-based collaborative that believes in: (a) supporting housing towards a home, (b) the importance of relationships, (c) walking with people to build community, (d) doing what it takes without giving up, and (e) reflexivity and growth (Region of Waterloo, 2014b). STEP Home's current programs fit within the following service categories: general and specialized street outreach, intensive support, supportive housing, and system level support including the Whatever It Takes program that works with individuals experiencing persistent homelessness to develop individualized plans and "work towards achieving housing stability" (Region of Waterloo, 2014b).

The HAWS rent assistance program provides participants with a "top up" of up to $350 to use towards rent. The amount of the "top up" is flexible and is dependent on participant income, the cost of rent, and specific housing needs. In addition to HAWS, participants that are part of the program are also connected to STEP Home's intensive support services. Each intensive support worker has, on average, a caseload of about 10-12 participants. However, this can vary from 8-15 depending on the extent of support needed. Activities of the intensive

support worker include regular check-ins with the participant, collaborative support planning, ensuring access to food and basic needs, navigating formal systems of support, liaising with healthcare providers to support care plans, assisting with applications for government services, helping to secure and maintain housing (e.g., landlord relations), and fostering social inclusion. Participants in the non-HAWS condition also receive STEP Home services. However, many participants are street-outreach connected rather than being intensively supported. Street outreach services are not as well defined. They often vary in intensity of support and usually are more focused on ensuring access to food and basic needs, helping to connect participants with other services, and supporting participants to secure housing. The organization's overarching objective is to build communities that are inclusive, where everyone has equal access to quality housing, employment, and support.

In early December, 2014, the Region of Waterloo conducted Registry Week, where a group of volunteers went into the community and surveyed shelters and various street locations in Cambridge, Kitchener, and Waterloo in order to capture the housing and health needs of individuals experiencing homelessness in the region (Region of Waterloo, 2014a). The survey was part of the 20,000 Homes Campaign, which is "a national movement of communities working to permanently house 20,000 of Canada's most vulnerable homeless people by July 1, 2018" (Canadian Alliance to End Homelessness, n.d., p.1). Registry week data identified 339 individuals who were experiencing homelessness in Waterloo region. Of that group, 281 were surveyed using the Vulnerability Index-Service Prioritization Decision Assistance Prescreen Tool (VI-SPDAT) (Region of Waterloo, 2014a). The VI-SPDAT (see Appendix A) is a tool that is used to assess vulnerability, meaning that people who score high on the survey have a higher risk of mortality than those who score low. According to the survey results, 45% of those

surveyed fell into the high-risk category, and 37% were identified as being at moderate risk. Scores on the VI-SPDAT were used by the Region to inform decisions related to the provision of rent assistance. The purpose is to target intensive housing and support services to those considered to be most vulnerable.

Research Process

In the summer of 2014, the Region of Waterloo was in the process of making changes to STEP Home services as a result of recent funding provided through the provincial government's Investment in Affordable Housing for Ontario (2014 Extension) program (Ontario Ministry of Municipal Affairs and Housing, 2014). The Region is using this funding to help house 40 individuals through rent assistance. In order to evaluate the success of the new rent assistance program, the Region of Waterloo enlisted the help of Dr. Geoffrey Nelson of Wilfrid Laurier University (WLU). Through Dr. Nelson, I was invited to work on the project. Joint negotiation led to the development of a contract between my advisor (Geoffrey Nelson), the Region and me, outlining the roles, responsibilities, and expectations for the project. It was determined that my roles as research coordinator and Co-Principal Investigator would be to oversee the project from start to finish. In collaboration with Dr. Geoffrey Nelson, the Region of Waterloo, KDCHC, and the STEP Home workers, I was responsible for assembling the measurement tools, assisting in the training and ongoing supervision of the peer interviewers, and completing the data analysis process by the end of August 2016.

Mixed Methods Approach

Based on the value of using a mixed methods approach in AHCS (Macnaughton, Goering, & Nelson, 2012), a similar research design was used in the current study. An embedded design in which qualitative interviews were fixed within a larger quantitative framework was

employed (Cresswell & Clark, 2007). Both quantitative and qualitative methods asked questions related to the effectiveness of the program, however, each was used to look at different factors. My advisor and I determined that the quantitative results would be impactful in terms of policy change, and that qualitative data would be essential in terms of providing a human voice to the experiences of participants and identifying factors associated with positive or negative life changes.

A qualitative focus group was also conducted with direct support workers in order to identify factors impacting implementation. As such, a complementary mixed methods approach was also used. Reasons for using a mixed methods approach include corroboration (*triangulation*), enhancement and clarification (*complementarity*) and to gain a more comprehensive understanding (*expansion*) of the research findings (Macnaughton et al., 2012; Padgett, 2012).

Research Design

This study used a pretest-posttest nonequivalent comparison group design to determine whether there is a treatment effect for HAWS recipients (Reichardt & Mark, 1997). The Region of Waterloo, in collaboration with a team of STEP Home workers, decided which individuals would receive the HAWS rent assistance. Selection criteria were based on worker knowledge and scores on the VI-SPDAT. Individuals with the highest VI-SPDAT scores were placed either on the rent assistance list or the priority list. Direct support workers noted that scores on the VI-SPDAT did not always accurately capture a participant's level of need. Therefore, decisions pertaining to which list participants were assigned to were also largely influenced by information gathered by the direct support workers who were providing support to participants in the community. There are approximately 40 individuals on the HAWS list and 60 on the priority

list. Individuals selected to be on the priority list were identified as being a good candidate for HAWS. However, they were not selected to receive assistance at this time. All individuals on the priority and rent assistance list were eligible to participate in the study. Individuals identified as experiencing homelessness and who were accessing STEP Home services at the time of recruitment were also eligible to participate. This design is non-intrusive (i.e., it does not alter the manner in which services are provided) and allowed my advisor and me to examine the impact of the rent assistance, making it a good fit for the project. Because the selection process is known, my advisor and I were able to control for threats to internal validity, including selection differences (Reichardt & Mark, 1997). For example, I was able to determine whether there was a significant difference in mean vulnerability scores between the HAWS participants and non-HAWS participants by computing an independent samples *t*-test. My advisor and I were also able to account for selection differences by comparing mean differences between groups on background characteristics collected at baseline (Reichardt & Mark, 1997). No significant differences were found between groups on the VI-SPDAT (mean scores for HAWS = 12.33; non-HAWS = 11.86). However, for many non-HAWS participants, a VI-SPDAT score was not available.

Participants

Selection criteria. Decisions regarding the allocation of rent assistance were informed by VI-SPDAT data collected during registry week, in addition to worker knowledge. This selection process was used to determine participant eligibility. Individuals selected to receive rent assistance were those who scored 8 or higher on the VI-SPDAT (i.e., those considered most vulnerable). In order to be eligible to participate in the treatment condition of this study, a person must: (a) be 16 years of age or older, (b) have scored 8 or higher on the VI-SPDAT, (c)

be connected to a STEP Home worker, (d) be living in the Waterloo region during the study period, and (e) be selected to receive rent assistance. In order to be eligible to participate in the comparison group, a person must: (a) be over 16 years of age or older, (b) scored 8 or higher on the VI-SPDAT, (c) be connected to a STEP Home worker, (d) be living in the Waterloo region during the study period, and (e) not be receiving any form of rent assistance.

Participant recruitment. Due to issues of confidentiality, my advisor and I did not have access to the names of the people who were determined to be eligible to participate in the study based on registry week data. Because all participants are, to varying degrees, connected to STEP Home, my advisor and I requested the assistance of the STEP Home team in the recruitment of participants. A recruitment letter (see Appendix B) was drafted and sent to STEP Home workers in request of their assistance. Because of their role in registry week, staff members at the Region of Waterloo are in a position to identify the names of eligible participants based on the selection criteria. My advisor and I asked staff at the Region to pass these names on to the STEP Home workers in order to facilitate the recruitment process.

Information about the study was introduced to eligible participants through STEP Home direct support workers as well as through community outreach by the interviewers. The study employed purposive, criterion sampling such that individuals scoring within a certain range on the VI-SPDAT were invited to participate. Individuals who did not complete the VI-SPDAT survey were still eligible to participate, as long as STEP Home workers identified them as being among the most vulnerable and placed them on the priority list.

Sample size. A total of 40 individuals were selected to be on the Region of Waterloo's rent assistance list. Due to limitations in funding and restrictions of eligibility, my advisor and I were able to recruit a sample size of 28 individuals for the treatment condition, and 32 for the

comparison group. As a result of constraints in time and resources, qualitative interviews were conducted with a sub-sample of participants. Six participants from each condition were determined to be sufficient for approaching saturation (Guest, Bunce, & Johnson, 2006)

Sample characteristics. A total of 60 participants were recruited at baseline (HAWS = 28; non-HAWS = 32). The majority of participants identified as male (HAWS = 17; non-HAWS = 23) and reported being born in Canada (HAWS = 93%; non-HAWS = 94%). A total of six (10%) participants identified as Aboriginal or First Nations (HAWS = 2; non-HAWS = 4), 39 (65%) as Canadian (HAWS = 20; non-HAWS = 19), one (2%) as Jamaican (HAWS = 0; non-HAWS = 1), and 9 (15%) as European (HAWS = 4; non-HAWS = 5). Participants were predominantly white and born in Canada even though Kitchener-Waterloo is a culturally diverse community with 22.3% of its population having immigrated to Canada at some point in time (Region of Waterloo, 2011). Eighty-two percent of participants reported having a mental health and/or substance dependence diagnosis (HAWS = 21 (75%); non-HAWS = 28 (88%)). There were no significant differences found between the two groups on any of these background characteristics. See Table 1 for a complete summary of demographic information.

Table 1

Comparison of Participants Who Either Received or Did Not Receive Rent Assistance on Demographic, Psychiatric Diagnosis, and Service Use Variables at Baseline

Characteristics		HAWS	Non-HAWS
		Mean (SD) or n (%)	Mean (SD) or n (%)
Gender (women)		11 (39%)	9 (28%)
Born in Canada		26 (93%)	30 (94%)
Ethnic or Cultural Identity:			
	Aboriginal	2 (8%)	4 (14%)
	Canadian	20 (77%)	19 (66%)
	Jamaican	0 (0%)	1 (.3%)

European	4 (15%)	5 (17%)
Years of Education Completed	10.74 (2.67)	11.06 (2.99)
Level of Education:		
Attended and/or completed elementary school	6 (21%)	5 (16%)
Attended and/or completed high school	16 (57%)	20 (63%)
Attended and/or completed business or trade school	4 (14%)	6 (19%)
Attended university	2 (7%)	1 (3%)
Marital Status:		
Married/cohabitating with partner	1 (4%)	2 (6%)
Single/separated/divorced/widowed	27 (96%)	30 (94%)
Worked continuously for at least one year in the past	18 (64%)	25 (78%)
Wartime service	1 (.4%)	2 (6%)
Current primary employment status:		
Employed/volunteer work	2 (7%)	3 (9%)
Unemployed/retired	25 (89%)	29 (91%)
Other	1 (4%)	0 (0%)
Would like to have a paid job in the community	18 (75%)	24 (86%)
Current sources of income:		
ODSP	13 (54%)	11 (39%)
OW	12 (50%)	15 (54%)
Pension	1 (.4%)	4 (14%)
Monthly Income	$748.86 ($377.27)	$601.80 ($391.64)
Total amount of time homeless (months)	57.08 (48.41)	36.52 (32.94)
Longest single period of homelessness	35.70 (28.85)	24.02 (28.95)
Housing stability at baseline	.14 (.33)	.36 (.45)
In the past 5 years, has been hospitalized for a mental illness for longer than 6 months?	2 (.7%)	6 (19%)
Has received treatment, counselling, or harm reduction services of alcohol or drug use	19 (68%)	20 (63%)

In the past 6 months, has been arrested, imprisoned, or served probation at least once.	10 (36%)	12 (38%)
In the past 6 months, has spent one or more nights in a hospital detox centre, jail, or shelter	15 (54%)	19 (59%)
Currently connected to an outreach worker	28 (100%)	28 (90%)
Length of time connected to outreach worker at baseline (months)	30.52 (60.14)	14.54 (21.56)
Diagnosed with a mental health and/or substance dependence issue	21 (75%)	28 (88%)

Housing stability at baseline was statistically significantly different between groups, with HAWS participants spending 11% of their time in stable housing compared to 39% of non-HAWS participants six months prior to baseline, $t(58) = -2.16$, $p = .035$. In line with a power-law policy approach, the Region and STEP Home employed a HAWS selection process that prioritized high need participants. The lower housing stability outcomes among HAWS participants suggest that the selection process was successful in meeting these objectives. HAWS participants also reported experiencing, on average, greater lifetime homelessness (HAWS = 57 Months; non-HAWS = 36.5 Months), and had been connected to their outreach worker for a longer period of time compared to non-HAWS participants. However, these differences were not statistically significant.

Qualitative interviews were conducted with a sub-sample of participants (n = 12). Eight participants identified as male and four as female. The sub-sample did not differ from the larger sample on background characteristics except that they were more likely to identify as Aboriginal or First Nations, $X^2 (1, N = 59) = 5.025$, $p = .025$

The overall attrition rate was 15% (nine of the 60 participants did not complete a follow-up interview). As expected, attrition rates were higher among non-HAWS participants, leaving 26 participants in the HAWS condition and 25 in the non-HAWS condition at follow-up. Reasons for attrition include missing contact information, incarceration, re-location, and death. Participants who dropped out of the study were significantly more likely to have been born outside of Canada, X^2 (1, N = 60) = 6.73, p = .035, and to have been diagnosed with a mental illness, X^2(1, N = 60) = 6.58, p = .010. No other background differences were found.

Direct support worker focus group participants. The STEP Home team is comprised of a total of approximately 38 direct support workers who conduct their work across 14 different agencies. Ten workers from four different agencies were recruited for the focus group (three male and seven female).

Data Collection

Quantitative interviews. Quantitative interviews were conducted with participants soon after they moved into housing, and again six months later. Baseline interviews began in July 2015, and follow-up interviews were completed by the end of August, 2016. Three peer researchers hired through KDCHC and myself conducted the interviews. The interviews took 1-1.5 hours to complete and were conducted at various locations and agencies in the community including Saint John's Kitchen, House of Friendship, Cambridge Self-Help Food Bank, the YWCA women's shelter, and the Cambridge shelter.

In order to establish consistency with the At Home project, similar outcome measures were used. This allows comparisons to be drawn across a wide range of factors. The measures and their psychometrics are described below (see Appendix F for baseline and Appendix G for follow-up interview protocols):

Demographics, housing, vocational and service use history (DHHS). The DHHS is a set of questions designed to gather information on a person's demographic, housing, vocational, and service use history (Goering et al., 2014). The questionnaire, developed by At Home's National Research Team, includes a number of measurement tools (AHCS, 2010). Questions were selected from a variety of sources including the 2006 Canada Census and the Community Mental Health Evaluation Initiative (AHCS, 2010).

Residential timeline follow-back (RTLFB). The RTLFB is a measurement tool used to assess housing stability. The questionnaire asks participants to recount housing moves over a 6-month period. Further information about each move is gathered, including: type of residence, cost of rent, and reasons for moving. The RTLFB has proven to be both a valid and reliable measure in terms of assessing individual variability in homelessness and residential stability (Goering et al., 2014). In a study where the RTLFB was administered to participants accessing housing and support services across a variety of agencies, the instrument was determined to have high test-retest reliability with intra-class correlation coefficients ranging from .80 to .93 across residential outcome measures. These estimates suggest that participants answered questions consistently and understood what was being asked of them (Tsemberis, McHugo, Williams, Hanrahan, & Stefancic, 2007). In order to assess the measure's validity, participant reports of days homeless were also compared to agency records. The means for each residential category captured in the scale (literal homelessness, stable housing, temporary settings, and institutional settings) were similar for both participant and agency reports with correlation coefficients ranging from .84 to .92. This analysis suggests that the scale is a valid measure of housing stability (Tsemberis et al., 2007). The RTLFB was also found to be sensitive to change over time. Taken together, research shows the instrument to be useful for assessing housing stability

for people experiencing homelessness (Tsemberis, et al., 2007).

Quality of life index – 20 item (QOLI-20). The QoLI-20 is a scale developed specifically for individuals experiencing mental illness that is used to assess perceived quality of life. The tool was originally developed by Lehman (1988) in the 1980s and was revised to produce the 20-item version in 1999 (AHCS, 2010; Uttaro & Lehman, 1999). The instrument has good face validity and includes questions related to daily activities, finances, relationships with others, and feelings of safety. A study assessing the psychometric properties of one version of the QoL inventory scale (S QoL 18) found that participants answered the questions both reliably and consistently. For five of the eight dimensions, Cronbach's alpha was greater than .70. Cronbach's alpha for the remaining three dimensions was greater than .60, indicating strong reliability. Sensitivity to change and internal consistency were also established by the researchers (Auquier, Tinland, Fortanier, Loundou, Baumstarck, Lancon, & Boyer, 2013). Higher scores on the S QoL 18 were also associated with better recovery and clinical outcomes, indicating that the scale has good predictive validity (Auquier et al., 2013). In the present study, Cronbach's alpha for the total quality of life score was .95 at baseline and .92 at follow-up, corroborating previous findings related to the scale's strong consistency.

Social support scale. A social support scale was not included in the original At Home study. Instead, items that inquire about the availability of a "confidante" were included as part of the Quality of Life-20 and Multnomah measures (AHCS, 2010). A specific social support scale was added to the protocol for this research in order to gain more information about the relationship between participant outcomes and their network of support. The scale consists of five items drawn from the Social Provisions Scale originally developed by a group of researchers at UCLA in 1978 (Cutrona & Russell, 1987). Previous

research has determined that the original and revised versions of the Social Provisions Scale are valid and reliable, making them suitable for use in research (Cutrona & Russell, 1987). One study found the Social Provisions Scale to be predictive of scores on the UCLA Loneliness Scale (Cutrona, 1982) and another to be predictive of post-partum depression (Cutrona & Buchwald 1984), indicating that the scale has good predictive validity. My advisor and I selected five items from this scale to be included as part of the research protocol. Two versions of the scale were used in order to evaluate changes in total and informal supports. The total support scale asked participants to answer each question including the support they received from their outreach worker (i.e., "For this question, **you may** include support from outreach worker: If something went wrong, no one would help me"). The informal support scale asked participants to answer the same questions but excluding this support (i.e., "For this question, **do not** include support from outreach worker: If something went wrong, no one would help me"). A similar six-item version of the scale was used in a study examining long-term outcomes of the Better Beginnings, Better Futures program, a community-based prevention program for primary school children. An alpha of .81 was computed for this scale, indicating good reliability (Pancer, Nelson, Hasford, & Loomis, 2013). In the present study, Cronbach's alpha for the informal support scale was .83 at baseline and .82 at follow-up. Cronbach's alpha for the total support scale was .61 at baseline and .73 at follow-up.

Multnomah community ability scale (MCAS). The MCAS is a self-report scale used to assess community functioning in order to match people with services that adequately meet their needs (Goering et al., 2014). Items are grouped according to the following four domains: (a) health, (b) adaptation, (c) social skills, and (d) behaviour. The instrument was originally

developed by a number of community mental health caseworkers in 1983 and has been well validated over time (Barker et al., 1994). One study in particular found all items on the scale, with the exception of social interest and intellectual functioning, to be highly correlated with a number of criterion variables (including age, sex, number of hospitalizations, and clinicians' global ratings). The scale was also found to be predictive of future hospitalizations, indicating that the scale has good construct and predictive validity (Barker et al., 1994). Additional strengths of the scale include high test-retest reliability with an intra-class correlation of .83 and strong internal consistency with a Cronbach's alpha coefficient of .90. (Barker et al., 1994). Several questions were adapted in the present study for sensitivity purposes and to meet local needs. For example, question two of the original MCAS scale was removed due to feedback from the direct support workers and peer researchers who felt that the question was not sensitive or pertinent to their community (i.e., "How much trouble have you had understanding things because you have some form of mental retardation, developmental disability, dementia, or brain injury?") Cronbach's alpha for the total MCAS score in the current study was .72 at baseline and .65 at follow-up.

Food security (FS). The FS scale is used to evaluate accessibility to nutritious food, another important factor contributing to quality of life. The scale was adapted from the USDA's 2008 Adult Food Security Survey Module by the AHCS researchers (AHCS, 2010). Some research indicates that the Household Food Insecurity Access Scale may be a more appropriate tool for evaluating food security among individuals experiencing homelessness (Holland, Kennedy, & Hwang, 2011). However, in order to maintain consistency with the At Home project, my advisor and I decided to use the FS scale. More research regarding the reliability and validity of this measure is needed (Holland et al., 2011). A reliability analysis of FS in the

current study found Cronbach's alpha to be .90 at baseline and .87 at follow-up.

Health, social and justice service use inventory (HSJSU). The HSJSU is a questionnaire developed to assess changes in service use and estimated service costs (Goering et al., 2014). The AHCS researchers developed the HSJSU because no pre-existing tool was adequate to evaluate service use among individuals experiencing homelessness (AHCS, 2010). Because the HSJSU was developed specifically for the At Home study, psychometric information does not currently exist for this measure (AHCS, 2010).

Perceived housing quality (PHQ). The PHQ is a 25-item scale that measures subjective ratings of housing quality among individuals living with mental illness and who are accessing a residential housing program (Tsemberis, Rogers, Rodis, Dushuttle & Skryha, 2003). The validity and reliability of the scale was tested with a sample of individuals who were participating in various housing programs across the United States. Factor analysis determined the scale to consist of four factors, including: (a) participant satisfaction with choice in terms of location and who one lives with, (b) safety, (c) privacy, and (d) proximity to community services and amenities. Fifty participants were asked to complete the scale twice over a 10-day period in order to determine test-retest reliability. Test-retest correlation coefficients for choice, safety, privacy, and proximity were .83, .92, .89, and .93, respectively. An alpha of .91 was calculated for all items in the scale, indicating strong internal consistency. The researchers found that participants residing in supported housing had higher ratings in terms of choice compared to participants in community residences or supportive housing. Moreover, participants in community residences had lower ratings in terms of privacy than those in supported and supportive housing. These findings suggest that the scale also has good discriminant validity (Tsemberis, Rogers, Rodis, Dushuttle & Skryha, 2003). The results from this study also provide

further evidence that a supported housing model is more in line with consumer preferences.

Six items relating to program choice were taken from this scale for use in the At Home study (AHCS, 2010). Another seven items were chosen from a housing quality scale developed by Toro and colleagues (1997) to assess level of satisfaction with one's living arrangements. This scale includes questions related to comfort, safety, spaciousness, privacy, friendliness, and overall quality. A test-retest correlation of .81 was calculated for this scale in an evaluation of an intensive case management program for individuals experiencing homelessness, indicating good test-retest reliability (Toro, Bellavia, Daeschler, Wall, & Smith, 1997). Cronbach's alpha for the PHQ was .88 in the present study.

Qualitative interviews. Qualitative questions were asked as part of the follow-up interview process with a sub-sample of the participants. The qualitative component was incorporated into the research design in order to complement quantitative research findings and to examine recovery outcomes. Qualitative interviews are more amenable to capturing recovery trajectories because they provide participants with the opportunity to openly discuss their experiences, drawing attention to factors that might have been overlooked by the quantitative interview protocol, including aspects of one's life in which participants attribute meaning to their experiences and are able to describe their identity construction. These interviews took, on average, 24 minutes to complete (i.e., from eight minutes to one hour) depending on the participants' level of engagement with the interview questions, and inquired about life changes experienced by participants over the course of the study period. The protocol was developed based on the narrative interviews that were conducted as part of the AHCS project and included questions related to the following domains: (a) housing, (b) service use (i.e., STEP Home support), (c) health and well-being, (d) relationships and social support, and (e) hopes for the

future. Whereas the quantitative aspect of the research is intended to examine the impact of rent assistance on a number of specific outcome measures, the qualitative component of the research is intended to help identify additional factors associated with positive and negative life experiences as they relate to housing, service use, health and well-being, relationships and social support, and hopes for the future. It is important to note that qualitative interviews were only conducted at follow-up and that change was interpreted based on participant reflections of their experiences over the course of the study period. Because qualitative interviews were not collected at both time points, a coding process similar to what was used in AHCS was not possible. For specific interview questions, see Appendix H.

Focus group interview with direct support workers. A focus group was conducted with direct support workers in order to gain greater insight into what their experiences have been with housing participants in the program. The focus group took place at KDCHC and took approximately 1.5 hours to complete. Questions were drawn from the AHCS protocol and were related to: (a) client-worker relationships, (b) barriers to housing, (c) housing choice, (d) rehousing, (e) HAWS program impacts, and (f) landlord relationships. This added component of the research contributed to a more comprehensive understanding of the complexities associated with housing participants and the impacts of the rent assistance program. See Appendix I for the complete interview protocol.

Procedure

Hiring, training, and supervision of peer researchers. In order to build a strong research team, promote empowerment, and build capacity among persons with lived experience (PWLE), three peer support workers were invited to assist in the data collection process. PWLE hold valuable insight and expertise of the mental health system and should therefore be involved

in evaluating services that impact them (Ochocka, Janzen & Nelson, 2002). This belief is in line with an empowerment theory approach. By creating opportunities for paid employment, my advisor and I also hoped to address some of the power imbalances that exist between research professionals and PWLE (Ochocka et al., 2002). Three peer support workers were hired through the Region of Waterloo's partnership with KDCHC.

Based on the learnings taken from the AHCS project, my advisor and I used the following strategies to promote the involvement of PWLE in research: providing opportunities to consult; hiring for research positions with clearly defined roles and responsibilities; and providing training in research as well as in "service provision and governance" (Nelson et al., 2016). Before moving on to the data collection stage, three training sessions were held in order to introduce the peer interviewers to the study and familiarize them with the interview protocol. Topics included in the training were: ethics in quantitative and qualitative research, conducting quantitative interviews, effective conversational interviewing, and interviewing in qualitative research. The training sessions also acted as an opportunity for consultation whereby my advisor and I obtained feedback and guidance on interview questions, recruitment strategies, and participant compensation. This process was critical to the development of a protocol that is sensitive to language and the needs of the target population. The involvement of PWLE also helped to build credibility in the community as a result of their prior involvement as peer support workers and helped to build trust among participants. Ongoing supervision was provided to the interviewers throughout the data collection process in order to provide support and ensure consistency.

Although the strengths of working with peer researchers far outweigh the limitations, some of the challenges faced by the research team include: inconsistencies in the early stages of

data collection, the amount of time dedicated to providing ongoing support throughout the project, and interviewer turnover. One peer interviewer left the project early due to personal health concerns. Another interviewer was hired to assist with the follow-up interviews. However, becoming involved in the project midway posed challenges including difficulties in identifying participants and being unfamiliar with outreach workers. Another peer interviewer left as a result of a new employment opportunity.

Factors that helped to facilitate collaboration with peer researchers included: allowing sufficient time to build trust, conducting ongoing formal and informal check-ins, remaining flexible, and building on individual strengths and knowledge. These findings are in line with learnings taken from previous research conducted with PWLE (Nelson et al., 2016; Ochocka et al., 2002).

Quantitative interviews. As part of the recruitment process, individuals who indicated interest in becoming study participants were asked to provide contact information so that initial interviews could be set up. Interviews were scheduled at a time and location that was convenient for both the participant and interviewer. A consent form was presented to participants prior to completing the baseline interview (see Appendix C for baseline consent form). I attended the first 10 interviews in order to provide initial support and supervision to the interviewers. Subsequent interviews were conducted one-on-one with the hired interviewer and interviewee. Participant responses were recorded on paper. As part of the interview wrap up, the interviewer debriefed the participant and provided them with a list of local resources. They were also informed of next steps, including a reminder that they would be contacted again in six months to set up a second interview. A $20 gift card to Walmart was then provided in addition to a $10 gift card to Tim Horton's as compensation. Participants were asked to sign a receipt. Interviewers

then stored all interview materials (including receipts) in a locked cabinet at KDCHC, the Cambridge Self Help Food Bank, or the Cambridge Shelter. Only my advisor and I had access to the data.

Participants were re-contacted six months after baseline in order to schedule a follow-up interview. The peer researchers and I made up to 10 attempts to contact a participant before considering them unreachable. The follow-up interview employed the same protocol as the baseline interview, with the exception of the DHHS. Questions related to PHQ were also included for participants that were housed in each group. On the same occasion as the quantitative portion of the interview, a sub-sample of 12 participants was asked several open-ended questions as part of the qualitative research component.

Qualitative interviews. The peer researchers and I conducted the qualitative interviews with a sub-sample of participants at the same time and location as the follow-up interview. The open-ended portion of the interview was audio-recorded in order to capture full detail of participant responses. Prior to proceeding with the follow-up interview, participants were presented with a third consent form that provided them with the opportunity to confirm or decline their participation in each of the quantitative and qualitative components (see Appendix D for quantitative follow-up consent form and Appendix E for quantitative and qualitative follow-up consent form). They were also asked to indicate whether or not they consented to the use of their quotations in reports of the results. Individuals were still able to participate in the qualitative component of the interview even if they refused the use of their quotations. After the interview was completed, I retrieved, transferred, and stored all data in Dr. Nelson's lab at Wilfrid Laurier University. The quantitative interview data was transferred onto a single SPSS

database and qualitative interview data were transcribed and transferred onto version 11.2.2 NVivo for Mac.

Focus group with direct support workers. An open invitation was provided to all STEP Home workers to participate in the focus group. Details about the focus group were provided at a regular STEP Home collaborative meeting and were sent by email via the STEP Home listserve. The workers were asked to meet at KDCHC, where lunch was provided. Ten workers from four different agencies showed up to participate in the focus group. The two Co-Principal Investigators of the study conducted the interview, Dr. Geoff Nelson and me. Participants were given consent forms, and my advisor and I explained how the focus group would proceed. An audio recorder was turned on and placed in the middle of the room. The interviewers then followed the interview protocol, asking alternating questions. Each question was allotted 10 minutes for discussion in order to ensure sufficient time. Participants were then given the opportunity to bring up any other topics that were not covered by the interview protocol.

Establishing the Quality of the Data

The following section outlines efforts to establish rigor in the research process.

Credibility. Credibility accounts for whether the researcher's interpretations are an accurate representation of the data (Padgett, 2012). Techniques used to ensure the credibility of the findings include: prolonged engagement, peer debriefing, triangulation, and member checking (Lincoln & Guba, 1985).

Prolonged engagement. Prolonged engagement is a strategy used by qualitative researchers to build trust with the people they are working with and to gain a deeper understanding of the social setting in which the research is being conducted (Padgett, 2012). In

working with STEP Home, I spent several days a week visiting the different agencies in order to conduct interviews and connect with the workers and peer researchers. This led to many informal discussions that contributed to my understanding of the community including changes in service delivery that were taking place. I also volunteered at a coffee shop that had been established by one of the participating agencies and that acted as a hub for workers who were meeting with participants. My engagement with Waterloo region over the course of the study period allowed me to build rapport with STEP Home participants and workers and develop a strong appreciation for the culture of the program, increasing the chance of obtaining an accurate understanding of the community and gather honest participant responses (Padgett, 2012).

Peer debriefing. Ongoing meetings with my advisor and peers in the Community Psychology program aided in the process of uncovering aspects of the study that I may have overlooked (i.e., language used in the interview protocol; strategies for engaging with the community) (Mertens, 2009). This practice helped to create a space to speak freely about some of the challenges I was experiencing, and allowed my advisor and I to address factors that may be hindering the research process. By creating opportunities to discuss the research with peers, researcher bias was also kept in check.

Triangulation. The research employs a mixed methods approach, where data from both quantitative and qualitative sources provided complementary information about the impacts of the rent assistance program. This approach facilitated the comprehensive understanding of the impact of rent assistance on individuals experiencing homelessness in Waterloo region (Padgett, 2012).

Member checking. Member checks are often used in order to ensure fair and accurate representation of the results (Mertens, 2009). Although this option was made available to

participants, many declined to be re-contacted about their responses. Therefore, member checking was not possible in this study. Interim and final results were shared at regular STEP Home collaborative meetings throughout the study period, providing an opportunity for attending members to question or discuss the findings. Feedback received at these meetings indicated that interpretations of the results were accurate.

Transferability. Transferability refers to the applicability of the research findings to other contexts. One technique used to ensure transferability is thick description. In providing a detailed account of the research context and process, I aim to promote transferability whereby external readers are able to determine whether the study results can be applied to other settings (Mertens, 2009).

Dependability. The dependability of a study is contingent on the extent to which the procedures and decisions made by the researchers are clearly documented so that replication by other researchers is possible (Padgett, 2012). Keeping an audit trail is one way to ensure dependability of the research. In keeping extensive field notes, including ongoing documentation of changes and reactions to the research, I was able to provide additional evidence to support the interpretation of results (Mertens, 2009).

Confirmability. Confirmability of the research is demonstrated by grounding the research findings in the data to avoid interpretations influenced by researcher bias (Padgett, 2012). Techniques used to ensure confirmability include keeping audit trails, reflexivity, and triangulation of the results (Lincoln & Guba, 1985).

***Audit trail, reflexivity, and triangulation*.** Information collected through field notes and participant interviews guided the qualitative analyses, ensuring that interpretations of the results were grounded in the data (Mertens, 2009). Ongoing engagement in reflexivity helped to

promote an awareness of personal reactions to the research that might bias my interpretations. As mentioned in the section on establishing credibility of the research findings, triangulation was achieved by incorporating both quantitative and qualitative research methods (Padgett, 2012). Data collected from each method complemented the other, providing further evidence to support interpretations of the results. For example, qualitative information on changes in relationships and social support was supported by quantitative data on the same topic.

Data Analysis Plan

Quantitative analysis. Following the guidelines for a pretest-posttest nonequivalent comparison group analysis, my advisor and I tested whether there is a statistically significant difference between groups for each of the outcome measures at baseline and follow-up. The treatment condition is the independent variable, and scales measuring days homeless, housing choice and quality, quality of life, total and informal social support, community functioning, food security, and use of hospital, emergency, and justice services are the outcome measures of the dependent variables. Items on each measure were summed to give participants a total score. Specific items were reverse scored to ensure that a higher total represented a more positive outcome on each measure (see appendix K for observed and potential range of measures and appendix L. for items that were reversed scored). Mixed model analyses of variance (ANOVAs) were then computed with time as the repeated factor and treatment condition (rent assistance vs. no rent assistance) as the between factor. Significant interactions between group and time were probed with simple effects analysis. A *t*-test was used to test differences for the PHQ measure. Chi-square tests were used to examine group differences for service utilization. Effects sizes (ESs) for significant effects that supported the hypotheses were computed using Cohen's *d.*

Qualitative analysis. I employed thematic analysis in order to interpret qualitative data. Thematic analysis has been determined to be a rigorous approach to qualitative research. This type of analysis also has a greater degree of flexibility compared to other more established approaches, such as grounded theory, as it is not theoretically-bound (Braun & Clarke, 2006). Braun and Clarke (2006) note that patterns do not passively emerge from the data but that researchers actively select and report patterns that are of interest to them. They emphasize the importance of matching methods to the research question and acknowledging them as decisions made by the researcher. The following is a summary of decisions taken by my advisor and I prior to qualitative analysis. We took an essentialist/realist epistemological approach to interpreting the data, where language is assumed to reflect and enable us to articulate meaning and experience. Patterns were identified from a top-down approach according to factors relating to housing, service use, health and wellbeing, relationships and social support, and hopes for the future. Accordingly, the themes were identified at the semantic, as opposed to a latent level, looking only at the explicit meanings of the data (Braun & Clarke, 2006). An essentialist/realist approach was also chosen based on its suitability in research employing mixed methods where the practical applications of the research findings are prioritized over theoretical positioning (Creswell & Clark, 2007).

Qualitative interviews were first transcribed by me and then transferred onto version 11.2.2. of NVivo for Mac. Following transcription, initial codes were made and organized according to emerging categories. These categories were then grouped into the following domains: (a) housing, (b) service use (i.e., STEP Home support), (c) health and well-being, (d) relationships and social support, and (e) hopes for the future (Nelson et al., 2015). The findings within each domain were organized according to whether they were direct impacts of housing or

influential factors. Responses from each group were then compared using matrix displays based on the five life domains, and organized according to the three life transitions that were identified in AHCS: (a) from street to home, (b) from home to community, and (c) from past to future (Macnaughton et al., 2016; Nelson et al., 2015).

Focus group analysis. Thematic analysis was also used to analyze the direct support worker focus group. Steps included in the analysis process included becoming familiar with the data by transcribing and reading through the focus group interview. The interview transcripts were then transferred to NVivo for Mac, version 11.2.2. Next, I developed initial codes by going through the transcripts carefully, assigning key terms to important areas of text. I then collapsed similar codes into broader categories. Three overarching themes were identified, including factors that hindered or supported the housing process at the individual, program, and community levels.

Ethical Considerations

As part of this study, my advisor and I worked with people who not only were experiencing homelessness but who had been identified as being among the most vulnerable of this population. As a result, there are some important ethical matters that need to be taken into consideration. For one, there is a heightened risk for emotional discomfort due to self-disclosure. Questions that inquire about a person's experiences of homelessness were asked as part of the interview process. These questions may have been "triggering" for many people. Based on previous studies, my advisor and I expected this discomfort to be minimal and temporary in nature. Participants were also given ongoing reminders of their right to decline to answer any question they were not comfortable with. Only one participant chose to stop the interview due to feelings of discomfort. In order to ensure that participants were not left without

any support at the end of an interview, local mental health, housing, and legal resources were provided along with a referral to their STEP Home worker. In order to protect the privacy of participants, confidentiality and anonymity was guaranteed as part of the consent process. Participants were also given the option to decline the use of their quotations in any reports of the results. Finally, in order to avoid the possibility of coercion, participants were reminded on each visit with the peer researchers or me that their participation was voluntary and that they could withdraw from the study at any time without consequence. Overall, we expected any risks that may have emerged as a result of participation in the study to be minimal and that the potential benefit of influencing policy outweighed these risks. A submission to conduct this research was made to Laurier's Research Ethics Board and was approved.

Knowledge Transfer

This study is part of a larger movement that is aimed at transforming the mental health housing and support system. As a result, it is critical that the research findings are made accessible to people at all levels of involvement. For one, my advisor and I hope to contribute to existing HF literature by submitting one or two articles for publication in peer-reviewed journals. Another important platform for publishing results is the Homeless Hub. The Homeless Hub is an open access online information forum that aims to share knowledge on issues of homelessness to all audiences including researchers, policy makers, service providers, and service recipients (Gaetz, 2014). In order to mobilize research findings, it will be important to develop a report that can be accessed through the Homeless Hub. Ongoing presentations have been made at STEP Home Collaborative meetings in order to keep the STEP Home team informed of the research. A brief presentation of the quantitative results has also been given to the Director of Homelessness Prevention at the Region of Waterloo. The findings were shared at a STEP Home

collaborative meeting on October 5, 2016 where direct support workers and other interested community partners were invited to listen and discuss how the results will be disseminated. Two community reports will then be developed, a five-page and a two-page document that will include a summary of the research results and key messages. A hard copy of these reports will be circulated to participating social service agencies, and these agencies will be encouraged to distribute to participants and anyone else that may be interested in the study. A digital copy of the reports will also be made available on the Region of Waterloo website and emailed to participants who indicated on the interview consent form that they would like to receive a copy.

Results

In this section, I provide a summary of the results for the primary quantitative outcomes, secondary quantitative outcomes, recovery outcomes, and direct support worker focus group. See Appendix J for the correlation matrices of outcome measures at baseline and six-month follow-up.

Primary Quantitative Outcomes

Housing. I hypothesized that participants receiving rent assistance would show significantly greater improvements in housing stability compared to those not receiving rent assistance. In Table 2, the average number of days and the percentage of time (i.e., average number of days in housing divided by total number of days) living in different types of housing over the previous 180 days are shown for the HAWS and non-HAWS groups at baseline and six-month follow-up. These results are also graphically depicted in Figure 1. Only the first type of housing, having one's own apartment, was tested for statistical significance, as all of the other types of housing are considered to be unstable.

Changes in stable housing were significant over time, $F_{(1, 49)} = 25.25$, $p < .001$, and there was a significant group x time interaction effect, $F_{(1, 49)} = 56.27$; $p < .001$. An analysis of simple effects showed that housing stability changed significantly over time as a result of being in the HAWS condition, $F_{(1, 49)} = 80.02$, $p < .001$, but not in the non-HAWS condition, $F_{(1, 49)} = 3.01$, $p = .089$ (Table 3). The ES for this significant interaction effect was 2.21, 99% CI [1.52, 1.92]. According to charts provided by Lipsey (1990, p. 58), an ES of this magnitude means that 99% of the HAWS group scored above the mean of the non-HAWS group.

Table 2

Average Number of Days and % Living in Different Types of Housing at Baseline and Six-month Follow-up for HAWS and non-HAWS Participants

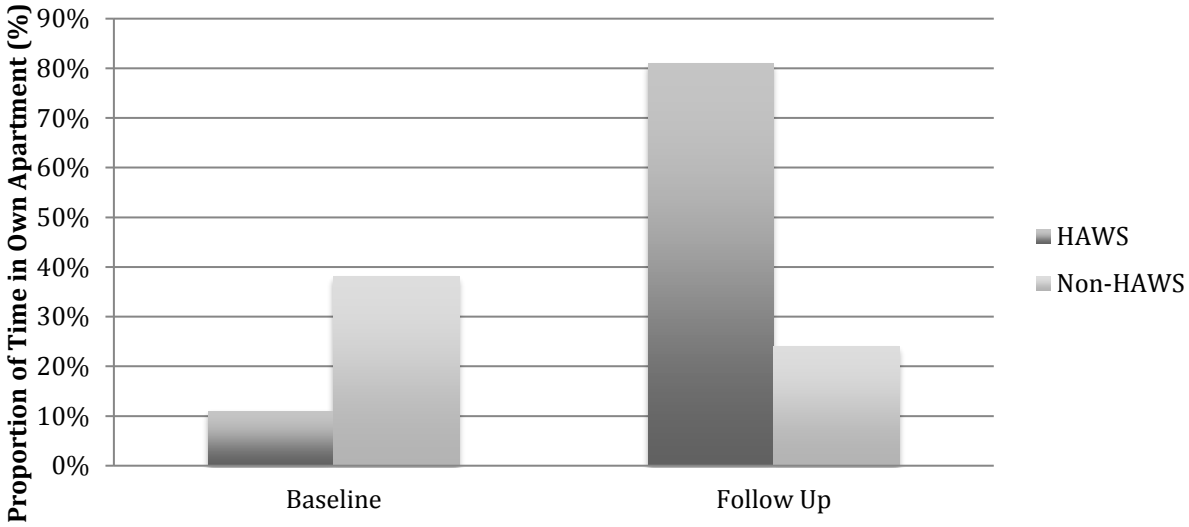
Type of Housing		HAWS	Non-HAWS
	Time	Days (%)	Days (%)
Own Apartment [a, b]	T1	20 (11%)	70 (39%)
	T2	146 (81%)	43 (24%)
Shelter, Couch Surfing, Jail, Hospital	T1	51 (29%)	43 (24%)
	T2	18 (10%)	82 (46%)
On the Street	T1	75 (42%)	18 (10%)
	T2	7 (4%)	4 (2%)
Hotel / Motel	T1	10 (5%)	0 (0%)
	T2	0 (0%)	5 (3%)
Rooming House	T1	14 (8%)	15 (8%)
	T2	0 (0%)	10 (6%)
Boarding House	T1	0 (0%)	7 (4%)
	T2	1 (.05%)	9 (5%)
Group Home	T1	0 (0%)	7 (4%)
	T2	5 (3%)	0 (0%)
Room in a House	T1	.2 (0.01%)	13 (7%)
	T2	0 (0%)	17 (9%)

Trailer	T1	0 (0%)	0 (0%)
	T2	0 (0%)	7 (4%)
Unknown	T1	10 (6%)	8 (4%)
	T2	3 (2%)	3 (2%)

[a] = time effect, $p < .01$ (2-tailed)
[b] = group x time effect, $p < .01$ (2-tailed)

Figure 1

Proportion of Time in Own Apartment at Baseline and Six-month Follow-up



I also hypothesized that participants receiving rent assistance would show significantly higher scores than those not receiving rent assistance on the PHQ measure. These findings are displayed in Table 3 and Figure 2. The result of this comparison was statistically significant, $t(35) = 2.56$, $p = .015$, ES = .86, 99% CI [.17, 1.54]. The ES of .86 means that 80% of the HAWS group scored above the mean of the non-HAWS group.

Table 3

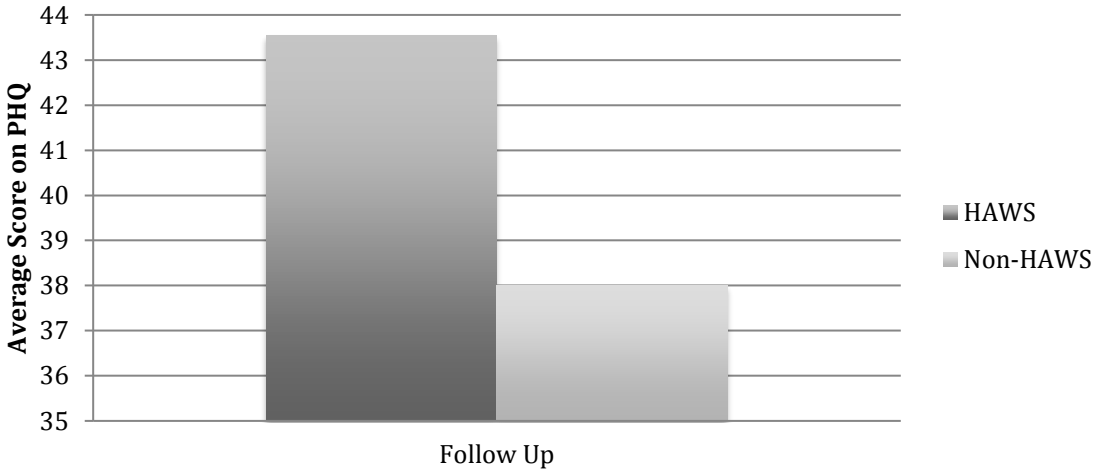
Comparison of Participants Who Either Received or Did Not Receive Rent Assistance on the PHQ

		HAWS	Non-HAWS
Perceived Housing Quality [a]	Period	Mean (SD)	Mean (SD)
	T2	43.55 (5.33)	38.00 (7.90)

[a] $p < .05$ (2-tailed)

Figure 2

Comparison of Participants Who Either Received or Did Not Receive Rent Assistance on Perceived Housing Quality (PHQ)



In summary, both primary outcome hypotheses, those concerning housing stability and housing quality, were supported.

Secondary Quantitative Outcomes

Quality of life. I also predicted that participants receiving rent assistance would show greater improvements than those not receiving rent assistance on measures of: (a) quality of life, (b) total and informal social support, (c) community functioning, (d) food security, and (e) reduced use of hospital, emergency, and justice services.

The results for the QOL measure are shown in Table 4 and Figure 3. Both groups showed significant improvements in the Total QOL score over time, $F(1, 49) = 16.60$, $p < .001$. A

significant time effect was also found for the following QOL subscales: finances, $F(1, 48) = 15.14$, $p < .001$, leisure, $F(1, 49) = 12.95$, $p = .001$, living situation, $F(1, 48) = 14.94$, $p < .001$, and safety, $F(1, 48) = 15.73$, $p < .001$.

Table 4

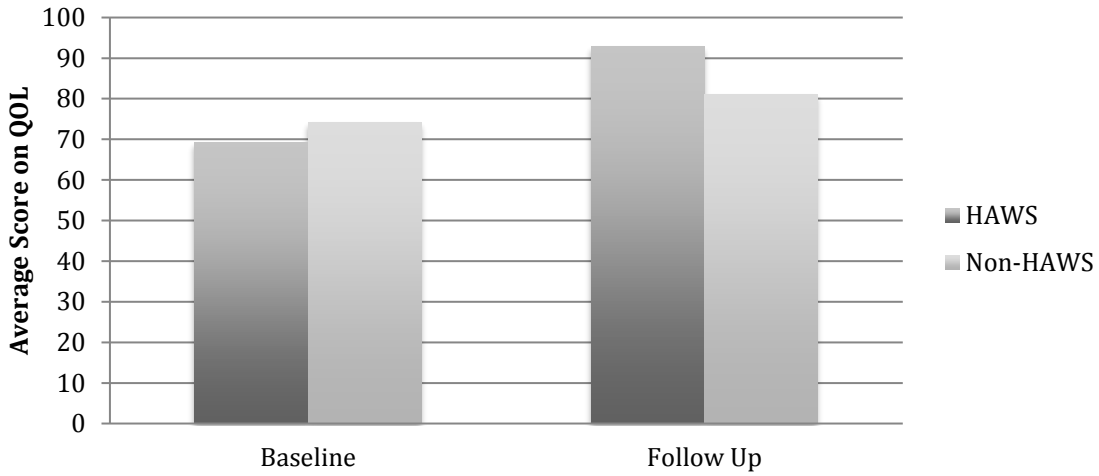
Comparison of Participants Who Either Received or Did Not Receive Rent Assistance on Quality of Life (QOL) at Baseline and Six-month Follow-up

		HAWS	Non-HAWS
Quality of Life	Period	Mean (SD)	Mean (SD)
Family	T1	15.23 (8.03)	15.44 (6.65)
	T2	17.15 (6.76)	15.68 (7.27)
Finances [a, b]	T1	5 (3.34)	4.56 (2.36)
	T2	7.56 (2.89)	5.2 (2.69)
Leisure [a]	T1	15.88 (8.25)	18 (7.85)
	T2	21.25 (6.46)	20.64 (6.64)
Living Situation [a]	T1	2.96 (2.18)	2.79 (1.98)
	T2	5.27 (2.01)	3.58 (2.26)
Safety [a, b]	T1	16.31 (6.34)	17.58 (7.12)
	T2	22.89 (3.7)	19.21 (6.85)
Life Overall [a, b]	T1	3.30 (1.89)	3.80 (2.08)
	T2	5.04 (1.26)	3.8 (1.73)
Social	T1	11.54 (5.73)	12.72 (4.92)
	T2	14 .29 (4.03)	13.08 (4.64)
Total [a, b]	T1	69.27 (28.97)	74.08 (24.97)
	T2	92.83 (15. 75)	81.04 (23.98)

[a] = time effect, p < .05 (2-tailed)
[b] = group x time effect, p < .05 (2-tailed)

Figure 3

Comparison of Participants Who Either Received or Did Not Receive Rent Assistance on Total Quality of Life (QOL)



There was also a significant group x time interaction effect for the QOL total score, $F(1, 49) = 4.91$, $p = .031$, the finance subscale, $F(1, 48) = 5.449$, $p = .024$, safety subscale, $F(1, 48) = 5.734$, $p = .021$, and life overall subscale, $F(1, 46) = 8.315$, $p = .006$. An analysis of simple effects showed that the total QOL score changed significantly over time as a result of being in the HAWS condition, $F(1, 49) = 20.18$, $p < .001$, but not in the non-HAWS condition, $F(1, 49) = 1.69$, $p = .199$.

Scores related to finances also changed significantly over time as a result of being in the HAWS condition, $F(1, 48) = 19.37$, $p < .001$, but not in the non-HAWS condition, $F(1, 48) = 1.21$, $p = .277$. Similarly, scores related to safety changed significantly over time as a result of being in the HAWS condition, $F(1, 48) = 21.07$, $p < .001$, but not in the non-HAWS condition, $F(1, 48) = 1.19$, $p = .281$. Finally, scores related to life overall changed significantly over time as a result of being in the HAWS condition, $F(1, 46) = 15.97$, $p < .001$, but not in the non-

HAWS condition, $F(1, 46) = .00$, p = 1.00. A group x time interaction effect for living situation also approached significance, $F(1, 48) = 3.571$, $p = .065$.

The ES for the interaction for the QOL total score was .82, 95% CI [.25, 1.39], which means that 79% of the HAWS group scored above the mean of the non-HAWS group.

Social support scale. The results for the social support measure are shown in Table 5. While the interaction between treatment condition and time was not statistically significant for the measure of informal support, simple effects showed that the HAWS participants experienced significant improvements over time, $F(1, 45) = 14.70$, $p = < .001$, whereas the non-HAWS group showed no significant change over time, $F(1, 45) = 2.39$, $p = .129$. The ES for informal social support was .46, 95% CI = [-.12, 1.04], meaning that 69% of the HAWS group scored above the mean of the non-HAWS group

No statistical difference was seen for either group on the total social support scale that included outreach support. HAWS participants showed no significant changes over time on the total social support scale, $F(1, 45) = .04$, $p = .834$. Although non-HAWS participants showed some improvement in total support compared to HAWS participants, these changes were not significant over time, $F(1, 45) = .94$, $p = .336$.

Table 5

Comparison of Participants Who Either Received or Did Not Receive Rent Assistance on Social Support at Baseline and Six-month Follow-up

		HAWS	Non-HAWS
Social Support	Period	Mean (SD)	Mean (SD)
Total Support	T1	15.17 (3.12)	12.91 (3.55)
	T2	15.00 (2.83)	13.70 (3.22)
Informal Support [a]	T1	11.04 (4.48)	12.00 (3.40)
	T2	14.00 (3.34)	13.22 (3.52)

[a] = time effect, p < .05 (2-tailed)

Multnomah community ability scale (MCAS). The results for the MCAS are shown in Table 6. While no significant interaction effect was found, simple effects analysis showed a significant improvement over time for HAWS participants on total MCAS score, $F(1, 48) = 5.71$, $p = .021$, but not for non-HAWS participants, $F(1, 48) = 1.51$, $p = .225$. The ES for total MCAS score was .23, 95% CI = [-.32 - .79], meaning that 58% of the HAWS group scored above the mean of the non-HAWS group. HAWS participants also showed significant improvements on the social skills subscale over time, $F(1, 47) = 4.37$, $p = .042$, compared to non-HAWS participants, $F(1, 47) = 1.32$, $p = .257$.

Table 6

Comparison of Participants Who Either Received or Did Not Receive Rent Assistance on the Multnomah Community Ability Scale (MCAS) at Baseline and Six-month Follow-up

		HAWS	Non-HAWS
Multnomah Community Ability	Period	Mean (SD)	Mean (SD)
Health [a]	T1	11.72 (4.25)	11.08 (4.42)
	T2	12.92 (3.86)	12.48 (3.00)
Adaptation	T1	6.36 (2.18)	6.50 (2.04)
	T2	7.28 (2.07)	6.71 (2.51)
Social Skills[a]	T1	13.00 (4.39)	12.63 (3.35)
	T2	14.56 (2.65)	13.50 (2.95)
Behaviour	T1	6.56 (2.04)	6.24 (2.47)
	T2	6.92 (1.99)	6.60 (2.27)
Total [a]	T1	37.64 (8.45)	36.40 (7.98)
	T2	41.68 (7.42)	38.48 (8.37)

[a] = time effect, $p < .05$ (2-tailed)

Food security (FS). Participants in the HAWS group also showed significant improvements over time on food security, $F(1, 46) = 7.65$, $p = .008$, whereas non-HAWS participants did not show significant improvements, $F(1, 46) = .69$, $p = .411$ (see Table 7). The ES for food security was .40, 95% CI = [-.18 - .97], meaning that 66% of HAWS participants scored above the mean of non-HAWS participants. While HAWS participants showed greater improvement over time compared to non-HAWS participants, the interaction effect was not significant.

Table 7

Comparison of Participants Who Either Received or Did Not Receive Rent Assistance on Food Security (FS) at Baseline and Six-month Follow-up

		HAWS	Non-HAWS
Food Security[a]	Period	Mean (SD)	Mean (SD)
	T1	14.38 (3.90)	16.42 (3.62)
	T2	16.88 (4.01)	17.17 (3.23)

[a] = time effect, $p < .05$ (2-tailed)

Health, social and justice service use inventory (HSJSU). No significant differences were seen between groups on justice services (see Table 8) or health and social service use (see Table 9) at baseline or six-month follow-up.

Table 8

Comparison of Participants Who Either Received or Did Not Receive Rent Assistance on Justice Service Use at Baseline and Six-month Follow-up

		HAWS	Non-HAWS
Outcome measure	Period	Yes (%) or Mean (SD)	Yes (%) or Mean (SD)
Have you had contacts with the police that did NOT result in detention, arrest, charge or conviction?	T1	12 (46%)	17 (53%)
	T2	12 (48%)	15 (60%)
How many times have you had contacts with the police that did NOT result in detention, arrest, charge or conviction?	T1	47.11 (69.66)	25.38 (60.42)
	T2	42.50 (66.86)	18.88 (50.86)
Have you been detained or taken anywhere by the police other than a police cell?	T1	6 (24%)	8 (26%)
	T2	5 (20%)	9 (36%)
How many times have you been detained or taken anywhere by the police other than a police cell?	T1	3.5 (4.32)	3.25 (3.81)
	T2	1.40 (.89)	1.94 (1.08)
Have you been held in a police cell for 24 hours or less?	T1	7 (27%)	11 (34%)
	T2	5(2%)	6 (24%)
How many times have you been held in a police cell for 24 hours or less?	T1	7.17 (10.67)	1.67 (1.12)
	T2	1.40 (.89)	2 (1.26)
In the past 6 months, have you been arrested?	T1	8 (30%)	10 (31%)
	T2	6 (24%)	8 (32%)
In the past 6 months, how many times have you been arrested?	T1	3.75 (6.65)	1.8 (1.14)
	T2	1.2 (.45)	1.5 (.76)
Did this arrest result in a formal charge?	T1	6 (75%)	8 (80%)
	T2	5 (71%)	5 (63%)

Table 9

Comparison of Participants Who Either Received or Did Not Receive Rent Assistance on Health and Social Service Use at Baseline and Six-month Follow-up

		HAWS	NON-HAWS
Outcome measure	Period	Yes (%) or Mean (SD)	Yes (%) or Mean (SD)
In the past month, have you seen a health or social services provider?	T1	23 (85%)	19 (59%)
	T2	22 (88%)	22 (92%)
How many times?	T1	9.8 (10.01)	6.29 (7.70)
	T2	16.31 (14.78)	10.04 (11.12)
At anytime in the past six months, have you called or been visited by a crisis team?	T1	6 (21%)	7 (22%)
	T2	1 (4%)	3 (12%)
How many times?	T1	1.33 (.52)	4.14 (3.80)
	T2	3.00 (na)	1.33 (.58)
In the past 6 months, have you been to a hospital emergency room?	T1	15 (54%)	15 (48%)
	T2	8 (32%)	11 (44%)
How many times?	T1	2.5 (2.89)	3.87 (4.02)
	T2	2 (1.51)	3.60 (5.21)
At any time in the past 6 months, have you been taken by ambulance to a hospital?	T1	9 (32%)	13 (41%)
	T2	8 (32%)	8 (32%)
How many times?	T1	3.17 (2.87)	2.38 (1.50)
	T2	1.56 (1.05)	2.80 (1.66)

In the past 6 months, have you been hospitalized for a mental illness?	T1	2 (7%)	3 (11%)
	T2	0 (0%)	2 (8%)
How many times?	T1	1.00 (.00)	5.33 (5.77)
	T2	0.00 (na)	1.00 (na)
In the past 6 months, have you been to any drop-in centres, community centres, or meal programs?	T1	21 (75%)	28 (88%)
	T2	21 (84%)	18 (72%)
How many times?	T1	104.3 (88.47)	68.23 (100.74)
	T2	74.48 (73.21)	85.56 (73.31)
At any time in the past 6 months, did you go to a food bank to get food?	T1	18 (64%)	26 (81%)
	T2	18 (72%)	19 (76%)
How many times?	T1	19.50 (45.84)	7.98 (9.14)
	T2	24.36 (44.48)	21.11 (41.93)

My secondary outcome hypothesis was partially supported with significant QOL findings and promising trends related to informal social support, community functioning, and food security.

Recovery Outcomes

The following research question was asked with regard to the qualitative interviews that were conducted with a sub-sample of participants: In what way does having access to HAWS change participants' experiences of the following five life domains: (a) housing, (b) service use (i.e. STEP Home support), (c) health and well-being, (d) relationships and social support, and (e) hopes for the future?

The findings are organized according to three life transitions that were initially identified in AHCS (Macnaughton et al., 2016) and the program components that impacted these transitions, including the HAWS rent assistance and STEP Home's intensive support services. See Table 10 for a summary of themes from the qualitative interviews. Ontological security and empowerment theory are used as frameworks to guide interpretations of the data.

Table 10

Themes from Qualitative Interviews with HAWS and non-HAWS Participants

Themes	Sub-themes
Transition From Streets to Home	Establishing a sense of ontological security
	Housing choice and financial freedom
Transition from Home to Community	Reconnecting with family and friends Becoming integrated into the broader community Giving back to the community
Transition from Past to Future	From past to future housing From past to future relationships, education, and employment From past to future health From past to hopes for the future
Program Components that Impact Life Transitions	STEP Home intensive support services Financial resources Bureaucratic restrictions

Five of six participants in the HAWS condition were housed in their own apartment six months after baseline. One participant lost his housing and was in the process of searching for a new apartment. Two of six participants in the non-HAWS condition were housed, one recently moved into his own apartment, and the other had been living in the same rooming home for one year. The remaining non-HAWS participants were living on the street, staying at a shelter, with a friend, or in a shared living situation.

Transition from streets to home. The greatest initial impact of housing is moving participants off the street and into their own home. When asked about what difference housing has made in his life, P014 said:

"Well, there's a lot of differences, I'm not homeless, I don't have to worry about where I'm going to stay that night or the next night."

All HAWS participants that were housed were happy to have made this transition, although some had a difficult time getting used to living in their own home. This experience was described as "culture shock" by P053, who struggled with having a new set of responsibilities as a result of living on his own. P059 also recounted some difficulty adjusting to his new housing:

"I had trouble getting used to it…still wanted to be back on the streets a bit…now I'm used to it and I couldn't see any other way of doing it."

Establishing a sense of ontological security. Once HAWS participants navigated the transitional stages of housing, having access to their own home led to an increase in stability and a sense of ontological security. This is indicated by participants' reflections on having greater choice and control over their living situation.

Having a place of one's own. Participants said that what they liked most about their housing was that it was their *own*, a space that was not occupied by others, and where they could exercise some control. HAWS participants were able to express relief from having to live in shared housing, such as P014 who exclaimed:

"it's my own place, yeah, finally."

On the other hand, many non-HAWS participants still experienced challenges as a result of living with others, including P031 who claimed:

"I have no control...and I can't squawk because it's not my home."

The preference for having one's own home was associated with greater personal freedom to do the things that one wants to do. This was well captured by P054 who said:

"it's mine, I can do whatever I want in there…I can come and go as I please…it's great…I can sit if I want to, I can sit, I like to just sit there and think and I can do that…if somebody knocks on my door, I don't have to answer, I don't have to do nothing nobody wants me to."

Privacy. Enjoying a sense of privacy was another positive outcome of housing for HAWS participants and an indicator of ontological security (Padgett, 2007). P014 said:

"I like when I have privacy, I can walk around wearing whatever I want."

P031, a non-HAWS participant still living in shared housing, spoke of the negative impacts of having "*no privacy"* stating that the woman she lives with *"walks in on me."*

Safety. Feeling safe is another component of housing that was stressed by participants in each condition. While participants that were not housed emphasized a need to find "a safe place", HAWS participants that were housed reflected on having a sense of security in their new home, such as P059 who said:

"My current housing is nice, it's safe and secure, it's comfortable, it's warm, it's cozy."

Participants that were housed in the HAWS condition were able to establish a secure home base free from the supervision of others, where they were able to exercise control, create their own routines, and experience privacy, satisfying conditions for establishing a sense of ontological security (Dupuis & Thorns, 1998).

Housing choice and financial freedom. The rent assistance helped to promote choice for the majority of HAWS participants, including P027 who said:

"well [the HAWS program] helped me manage to find an apartment quicker than say OW would if I was just on OW alone."

However, choice continued to be limited by affordable housing options. P053 struggled to find housing in his desired neighbourhood:

"I understand there's more affordable places, you know, for me personally, all those places are just, like, triggers…oh but it's all you can afford."

For some, having access to HAWS also meant greater financial freedom outside of the home. P010 said that this financial freedom meant that she is:

"able to go to the store and have actually money in your pocket that if you saw something that you liked, that you'd be able to buy it."

She said that this opportunity allowed her to reclaim her "*dignity, gives you back your dignity."*

Greater financial security also led to improved access to food and basic needs, P010 said:

" I have a little bit of extra money in my pocket that I can go out and go grocery shopping."

However, some HAWS participants continued to struggle financially, even with the "top up", including P027:

"I'm paying for the hydro as well, so now they're taking like over 70 bucks every month off my cheque, so I'm left with two hundred bucks a month…so once I get meats for my fridge and stuff and then what I need to for the house if I don't get it from [the food bank], and then I'm left with like 10 bucks to my name."

Non-HAWS participants who were still living on the street continued to experience barriers with regard to meeting basic needs, such as P025 who disclosed:

"it's frustrating [sighs] I don't like it, being diabetic, it's a pain in my butt, always worrying about food, always worrying about where I'm gonna spend the night or sleep that night, so it's very, very hard on me, very stressful"

Transition from home to community.

Reconnecting with family and friends. Once participants were able to stabilize themselves in their new homes, it became possible to start reconnecting with family and build new relationships. P010 said that she was able to:

"...see my family again…my family wouldn't come see me because I was homeless and I was in my addictions."

P014 was able to make:

"new friends moving into this house...people who I met being in this home are, they're positive, it's a positive group of people."

Negative social support was more apparent among non-HAWS participants, including P055 who said of her family:

"A lot of negative support there because…they tell me I put myself in this position."

Because it is often difficult to trust others while living on the street, many non-HAWS participants tended to keep to themselves. This was well articulate by P055 who made the following impactful statement:

"I wouldn't really consider them friends, it's more like enemies because everybody's out here, living on the streets, just trying to survive, like it's a dog eat dog world out here, man."

Becoming integrated into the broader community. Housing is an important initial step towards becoming a part of the community. As P059 noted:

"everybody else has a home...except for a few people, and I have a home so it's more like I'm a part of the society, a part of the general ongoing society".

Landlord discrimination acts as a major barrier, preventing participants in both the HAWS and non-HAWS condition from being able to take this first step. P025 notes that:

"landlords…are very biased, very ignorant because of the way, how I look, landlords don't like that very much, 'cause of my appearance, just hard finding places to live and…having landlords give me a chance."

Once participants were able to secure housing, past experiences of stigma shaped the way participants felt that they were perceived by their neighbours. P010 said:

"I was afraid at first, oh gosh, my neighbours must think, oh there, yep, she's a user, or she's a dope addict, okay these kind of people are going to be around here, you know, and I was afraid of that."

Participants talked about experiencing loneliness or isolation after moving into their housing or as they moved away from negative social contacts. P027 said it:

"...kind of comes back a little bit more, now that I'm housed, because now…I'm feeling lonely, so it's a little bit hard to handle when you have all that time now."

Findings from the AHCS found that a number of participants experienced isolation after moving from the street into their own apartment (Kirst, Zerger, Wise Harris, Plenert & Stergiopoulos, 2014; Polvere, Macnaughton, Piat, Cook, Judith & Mueser, 2013). Patterson et al. (2013) suggest that loneliness experienced at the initial stages of housing may be a necessary consolidation phase for some participants before moving forward in their recovery. However, efforts to facilitate inclusion are important as participants navigate this new chapter of their lives.

Giving back to the community. Once participants were able to establish a sense of stability by means of having a home, many became oriented towards helping others and making contributions to their community. P014 reflected on becoming a support system to those closest to him:

> *"if there's friends of mine who's in need of a place to stay that night, I can help them out, people that helped me out...so I can be a positive...support system for people in worse positions that I am in, yeah, I know what it's like to be in that position."*

Giving back, such as through volunteer work, also helped to facilitate integration into the community. Participants that were not housed were also oriented towards helping others, but acknowledged the importance of finding a home and becoming stabilized first, as stated by P053:

> *"well that's just it, I wanna help, but I'm not, I can't, I gotta help myself."*

Transition from past to future. Participants' orientation towards the future was impacted by whether or not they had secured housing. The stability associated with having one's own place allowed participants to reflect on the past and move forward with new goals. This was captured by P027 who said,

> *"I wouldn't be able to sit back and look at the things I've overcome to be where I am today...if I didn't have a place over my head...[if] I wasn't able to stable myself."*

From past to future housing. HAWS participants tended to indicate plans to stay in their current housing or were taking time to find housing that better matched their needs and preferences. For example, P014 was looking to find an apartment that was in a better location for him and that was not in a basement suite:

> *"it gets really depressing down there…that's why my worker is looking for an apartment for me in Cambridge."*

Non-HAWS participants tended to have more short-term plans and some were under pressure to find housing as soon as possible, including P031 who said that

"… time is of the essence, I need to be out of there...by this summer."

From past to future relationships, education, and employment. Participants in both conditions had similar desires for their future. They wanted to work on building relationships with family, go back to school, and find employment. For many participants in the HAWS condition, they had already started to search for jobs or re-connect with family. P059 hoped to continue to build relationships with his family and wanted to: *"make them even better..."*.

Non-HAWS participants were more likely to note the importance of securing housing or going to treatment before they could accomplish these aspirations. P031 talked about the need to have a home in order for her to be able to have her grandchildren over again, so that:

"They can come over and spend a night...I can cook for them, we could watch TV and laugh."

P025 also noted that his future plans were dependent on meeting other needs first, for example, he said: *"After…going through rehab and everything, I'd like to apply back to school"*

From past to future health. Health was a major focus for participants in both conditions. All participants receiving HAWS reflected on feeling healthier as a result of housing, and many had plans to continue working on their health. P059 noted that he was planning to:

"get stronger and more rested, and more energized to do what I want to do."

Many non-HAWS participants disclosed experiencing deterioration in their health, including P031 who said,

"I've progressively gotten worse, I have the second cancer, over the last 6 months". Because of the severity of health complications among many non-HAWS participants, addressing these concerns were at the forefront of their plans for the future.

From past to hopes for the future. HAWS participants described experiencing improvements in their mental health and well-being. P014 said that he has:

> *"...been feeling better in a way since I've been housed…it's definitely made a huge difference in my mental health, having my own place"* and expressed a change in his life satisfaction, stating that *"before I wasn't satisfied with my life, now I am."*

HAWS participants, including P010, were able to reflect on past hardships, and expressed

> "looking forward to a better future."

Non-HAWS participants, on the other hand, tended to experience less improvement in their mental health. P045 expressed feeling tired of being dissatisfied with their life, stating:

> *"I don't want to always be jealous of the other family walking that poodle because I feel like that poodle is getting more of a life than I am",* noting that he doesn't *"really feel like there is a future for me".*

A general lack of hope was more evident among non-HAWS participants, who felt frustrated with continually being let down, particularly with regard to housing. As P031 said,

> *"you can hear that so long until you know darn well you're forgotten about because there's no sense of hope, you're losing hope, you lose hope".*

Program components that impact life transitions. Program components, including the HAWS rent assistance and STEP Home intensive support services, played an important role in helping participants to find and secure housing.

STEP Home intensive outreach support. Participants in each condition highlighted the role their outreach worker played in supporting them to find housing and meet other basic needs. Participants in both conditions described having a positive, trusting relationship with their outreach worker. For example, P025 said of his intensive support worker,

"I can trust him, bottom line I can trust him."

The workers helped participants navigate the housing system, including P010 who, referring to her intensive support worker, said:

"she believed in me, she believes in me and got me a home, believes in what I'm doing and she encourages me".

The workers also provide support that is often not available otherwise, as P014 said of his worker:

"there's a lot of people who will get scared, a lot of people who will say they don't want to work with me anymore…but he has taken it like a champ… and he's still very supportive, he doesn't get disappointed in me for getting angry, he doesn't look down on me, he understands one hundred percent why I do".

In addition to outreach support, participants often drew on other community resources to meet their needs, particularly among those who continue to be un-housed. P031 identified a demand for more of these resources, and said the following in reference to one of the central drop in centers located in Kitchener:

"...they got a darn good staff...they float pretty well, I think they need some more help, some more well what would you say, outreach"

Financial resources. All participants discussed the critical role rent assistance played in being able to access or afford a home. The majority of participants in the non-HAWS condition

identified limited financial resources as the main reason for not being able to secure housing. Some participants, like P031, are living in unsatisfactory housing because they cannot afford anything else.

> *"right now, it's just inadequate housing, well it's something that I've had to tolerate because…before I got this old age pension, I only got $600 and something a month, you can't rent a backhouse for that."*

HAWS participants, on the other hand, were able to access housing that they would not have been able to access on OW or ODSP alone, reducing the amount of financial strain on participants. This is captured by P005, who stated:

> *"With the program giving me the top up, it's allowed me to relax and not have to scramble so much"*

Bureaucratic restrictions. In order to be eligible to receive HAWS, participants must apply for government support and may not be receiving financial help from any other sources. These requirements sometimes limited choice for participants, including P053 who continues to search for housing**,**

> *"if my mom covered it and I just paid half of it with all the money from HAWS and then, you know, I'd be in a safe place and I could get a job, then I could pay it, and then that would be the start to get out...but they want you to start, like, everything on your own from the bottom, you know, get this place that costs $600, in a shared accommodations"***.**

While gaining access to HAWS promotes choice and aids in the process of securing housing, eligibility requirements associated with HAWS can also restrict what types of housing are available to participants.

Summary. The majority of participants in the HAWS condition were housed in their own apartment compared to non-HAWS participants who were predominantly living in shared housing or on the street, suggesting that the rent assistance helped participants to secure housing. Participants in both conditions indicated a preference for living in their own place and said that rent assistance either helped or would help to make this possible. In addition to rent assistance, program components that were critical for securing housing were STEP Home's intensive support services. Together, these components aimed to empower participants by providing them with the resources to obtain housing and the opportunity to make choices about their living situation. At the same time, eligibility requirements for HAWS sometimes posed a barrier to housing choice, limiting self-determination.

Three transitions were notable among participants that were able to secure housing: the transition from street to home, from home to community, and from past to future. HAWS participants were more likely to make these transitions, as they were more likely to be housed compared to participants not receiving HAWS. Participants who were housed experienced greater choice and control over their living situation and greater housing and financial stability. These changes reflect an increase in ontological security and empowerment and were associated with improvements in physical and mental health. Loneliness was identified as one negative outcome of housing as participants had more time to self-reflect or as they began to move away from negative social contacts. Sub-themes relating to building relationships with others, community integration, and positive hopes for the future were more apparent among HAWS compared to non-HAWS participants. Non-HAWS participants tended to described feeling less hopeful, indicating a need for more supports and services in place to address the needs of those that continue to live on the streets or in the shelters.

Implementation Outcomes

I also asked the following research question: What are the direct support worker perspectives on the rent assistance program and what factors helped or hindered the implementation process?

The primary objective of the rent assistance program is to house participants and to help them maintain their housing. Factors that support or hinder program objectives can be understood at the different ecological levels, including: (a) individual, (b) program, and (c) community. Below I present the analysis of the focus group interview with the STEP Home direct support workers according to each of these levels.

Individual level factors that support or hinder program objectives. The following is a summary of individual level factors that impact the process of securing housing for participants, including participants acuity level and tenant guests.

Participant acuity level as a barrier to securing housing. The STEP Home program works with participants who have complex needs, making the housing process more challenging. These challenges include *"a lack of insight"* among participants or difficulty in locating participants, as many may be *"cycling between prison, shelter very quickly".* As a consequence, some workers felt that: *"For people who are low acuity, with the rent subsidy, it happens and it works well"* but that they are faced with more challenges *"the higher up the acuity scale."*

Tenant guests as a risk for housing loss. Another individual level factor that can impact a participant's ability to maintain housing is when they offer accommodation to guests who may still be living on the street and/or who are drug-involved. As one worker described:

> *"…they get housed independently, then yeah, they feel lonely, and then they invite everybody to stay with them, and then they get evicted…it's just this giant web."*

Program level factors that support or hinder program objectives. In the following section, program level factors that impact the housing process are identified, including the client-worker relationship, working from a team approach, and program requirements.

***Client-worker relationship as a facilitator to the housing process*.** Trust developed between the worker and participant helps to facilitate the process of securing housing. As one worker mentioned, a participant:

> *"might have some feelings about being in housing or looking for housing, but if they start to trust you…it's just a little bit easier..."*

Having a positive client-worker relationship meant that participants were more likely to cooperate with the worker in terms of attending meetings with landlords and signing documents necessary to obtain housing. Meanwhile, a lack of rapport between participant and worker can hinder the housing process.

> *"…if someone's moved into housing really quickly, there isn't a relationship between participant and worker…like, the relationships aren't clearly understood, or developed, or well on their way, things can just unravel really quickly and then it's hard to sort of pick up the pieces…"*

Staff turnover can act as a barrier to building rapport with participants. One worker reflects on their experience supporting participants after a large number of staff left:

> *"…we had a bunch of people leave, that hand off happened, so that's been extremely challenging, not to have a rapport with people, but then expect to house them…without that building of rapport makes things a lot more challenging."*

***Supporting participant learning as a way to promote housing retention*.** Supporting participant learning as they adapt to their new housing can help to support housing retention,

particularly when their initial housing did not work out. This is captured by one worker who said:

> *"And taking some learnings, I think I've seen that, like, with the rehousing piece is that often…there's been some…things that have gone very wrong with the first housing but then…you can kind of break it down a little bit more and kind of say, what went wrong…how are you going to change that for the future, what's your new housing going to look like, and, so there's some learnings to that."*

One way to support participant learning is to engage participants in communication about tenancy rights and responsibilities. These conversations may help to empower participants as they take on their new role as tenant (MacLeod, Nelson, O'Campo & Jeyaratnam, 2015).

Working as a team as a way to strengthen supports available to participants. The workers reflect on the benefits of working as a team as opposed to working on their own. One benefit for participants is that it provides them with a greater network of support from which to draw on. This may be particularly important to avoid the negative consequences associated with staff turnover. One worker noted:

> *"…what I've seen in the past is the client will have one worker where they work with them for five years or a long time, which is really positive in some ways but I've seen it when that person leaves, it becomes really negative and they have difficulty moving on from that and feel a lot of abandonment issues."*

A team approach also helps to lessen the amount of stress on individual workers.

> *"I'm one to one support and I think that poses…challenges for the worker because you're the only person so that's a lot of responsibility, so if I'm sick one day, I'm sick and there's not like a real back up."*

Workers often find themselves having to play many roles in addition to providing support to participants. One suggestion that fits within the idea of working from a team approach is establishing distinct roles for different team members. For example, one person would be assigned the role of support worker whereas another person would be responsible for dealing with issues related to housing; that way, workers can avoid playing *"good cop, bad cop all the time."* This would allow the client-worker relationship to remain intact and place the worker in a better position to support participants as they transition to the next stage of the housing process.

Program requirements as a barrier to securing housing. At times, program requirements can act as a barrier to housing. For example, one worker noted that:

> *"…to get approved for HAWS, you have to get in a birth certificate, or some sort of ID, and sometimes that is impossible to get."*

Participants are also required to live in one-bedroom apartments. However, one-bedroom apartments are not always available. One worker described their experiences where:

> *"…[they] found people two bedroom apartments that are like $780, and [they] can't house them there because they have to have a one bedroom."*

Other requirements, such as reference checks, can also be a barrier. Workers also often need to complete paperwork with participants as part of the program requirements and in order to secure housing. Engaging participants in this aspect of the work can be challenging:

> *"…these are people who have been on the streets for years and…paperwork scares them, cause then it's a trail on them, or whatever the reason is, but there's a lot of individuals that are terrified of that and now they don't qualify [for housing] because we can't do the paperwork."*

Greater flexibility in terms of eligibility requirements for HAWS may help reduce some of the barriers workers experience as they support participants to find housing.

Community-level factors that support or hinder program objectives. In the following section, a number of community level factors that support or hinder the housing process are identified, including landlord discrimination, housing affordability, and promoting awareness in the community.

***Landlord discrimination as a barrier to securing housing*.** Another major barrier to housing clients is landlord discrimination. Workers reflect on their experience with landlords who are unwilling to accept applications from participants on the basis of mental health or addictions issues:

> *"…there's certain individuals that you can't physically take to the landlord and the landlord is just gonna say, okay yeah I'm gonna rent to this person because of their own, maybe hygiene, whatever, mental health, whatever it is."*

Some barriers exist prior to meeting with a landlord, such as discrimination found in postings for apartment vacancies. The experience of rejection by landlords can have an impact on an individual's willingness to continue to engage in the housing process. Building relationships with landlords can help to facilitate the housing application process, and ease some of the anxiety participants may experience because:

> *"…you know you're going to be treated with dignity if you have a relationship with the landlord or if you know that…there's some work that has taken place beforehand."*

The idea of establishing a landlord network was seen as a positive way to build connections between landlords and the program, build awareness on issues related to mental health and addictions, and reduce barriers associated with discrimination. Funding to help pay for any

damages incurred by participants is also mentioned as a way to provide incentive for landlords to house participants.

Housing affordability limits housing availability and choice. The cost of housing was identified as being the biggest challenge in finding housing for participants. One worker stated:

> *"One bedrooms are expensive now, like, look them up, they're like $850, $900 bucks there's just, there's not places, they're not there, that are affordable."*

The HAWS program helps to address the issue of housing affordability and choice:

> *"…because OW and ODSP don't give you enough for rent, so that extra money helps you get a better place"*

However, with rental costs on the rise, affordability continues to be a limitation, even with access to rent assistance

***Promoting awareness and program buy-in within the community*.** A need to promote awareness and educate the community on matters of mental health and the importance of housing individuals experiencing chronic homelessness is emphasized as a way to establish community buy-in and reduce barriers associated with stigma and discrimination, including:

> *"…more CTV exposure, some sort of exposure that explains the benefits for not only us, but for our community, our society, and the landlords."*

This process may lead to more opportunities for housing and community integration among participants.

In summary, there are individual, program, and community-level factors that both hinder and facilitate the housing process. Factors that make it difficult to secure housing include the acuity level of participants, restrictive program requirements, landlord discrimination, and lack of affordable apartments. One way to address some of these barriers is to strengthen

relationships between participants, workers, landlords and the broader community. Supporting participant learning as they transition into housing will also help to ease conflict with landlords and the surrounding community. At the program level, establishing a landlord forum and fund to pay for damages may create greater incentive for landlords to house participants. At the societal level, increasing the amount of affordable housing stock will address issues related to limited housing supply.

Discussion

As discussed in the theoretical framework section earlier in the thesis, homelessness emerges as a result of the institution of oppressive social structures, including the government enactment of policies that are aligned with a capitalist, neoliberal agenda. Recently, researchers, advocates, and key champions in the community were able to push for change by resisting oppressive social structures within the context of the 2010 Winter Olympics in Vancouver and growing public concern over issues of homelessness and mental illness. These factors contributed to the implementation of AHCS and consequently led to an increase in federal funding towards supported housing programs (Macnaughton et al., 2013). These changes have helped to address issues of systemic inequality by directing resources to people who have been disadvantaged within a capitalist society, representing a shift at the structural level. Following the framework for change set out by structuration theory (Bernard et al., 2007), proponents of HF were able to take action by challenging social processes associated with the traditional continuum model of care approach to service delivery and advocating for change in the allocation of resources. Political pressure tactics were successful with the implementation of AHCS, leading to a more equal distribution of housing resources based on price (i.e., rent assistance aids in the affordability of housing) and rights (i.e., HF promotes entitlements to

housing among those in need) (Bernard et al., 2007). Issues related to proximity or the availability of housing continue to be a barrier, indicating a need for more federal investment in affordable housing stock.

The changes noted above have also helped to produce conditions of empowerment at the community, organizational, and individual level (Zimmerman, 2000). The present study is one example of this. With the addition of rent assistance, STEP Home is able to more readily secure housing for participants and, in turn, promote self-determination among the population it serves. STEP Home is therefore an empower*ed* organization that is able to impact policy and meet the needs of the people they support and an empower*ing* organization that gives participants control over their own lives. As participants become more integrated into society, they are able to become more actively involved in community and civic matters, contributing to empowerment at the community level. The findings are discussed in terms of how they are aligned with structuration and ecological empowerment theories and in terms of each of the research questions and hypotheses.

Quantitative and Recovery Outcomes

Housing stability. It was hypothesized that the addition of rent assistance to the STEP Home program would improve the housing stability of those receiving rent assistance compared with those not receiving rent assistance. This hypothesis was supported. Moreover, the results from this study are in line with previous research on rent assistance plus case management programs, including the McKinney Research Demonstration project (Hurlburt et al., 1996) and the HUD-VASH program (Rosenheck et al., 2003; Tsai et al., 2011). The present study showed that participants who received HAWS plus intensive support services had 57% more days in stable housing than those receiving support services only; whereas participants enrolled in the

HUD-VASH program had 25% more time in stable housing than standard care (Rosenheck et al., 2003). The HUD-VASH findings are based on housing stability outcomes at a three-year follow-up whereas housing stability outcomes in the current study are based on 6-month results. We might expect three-year housing stability results in the current study to be more comparable to those found in the HUD-VASH evaluation as participants in the comparison group are able to catch up to HAWS participants and acquire stable housing over time.

Study findings on housing stability are also in line with those found in AHCS and in Nelson et al.'s (2007) review of the literature. An analysis of the six-month AHCS results found effect sizes of 1.38 for ACT participants (Aubry et al., 2016) and 1.30 for ICM participants (Stergiopoulos et al., 2015) on housing stability. ACT participants in HF were stably housed 76% of the time compared with 23% of TAU participants at six months (Aubry et al., 2016). Over the six-month period of the present study, HAWS participants spent an average of 81% of their time in stable housing compared to 24% for the non-HAWS group, with an even larger effect size of 2.21. These findings can be compared with those reported in Nelson et al.'s (2007) review of the literature on the effectiveness of different interventions for people with a history of homelessness and mental illness. They found that programs combining permanent independent housing with support to have greater impacts on housing stability (ES = .67) than ACT services alone (ES = .47) or ICM services alone (ES = .28), suggesting that rent assistance plays a critical role in stabilizing participants. Effect sizes in AHCS and in Nelson et al. (2007) review were conducted at the longest follow-up interval (24 months), which may account for why they are lower than what was found in the current study. Ongoing follow-ups with participants would allow for comparisons at later follow-up intervals. However, it is important to use caution when

making direct comparisons to AHCS given that participants in the present study received different types of support services.

Housing quality. It was also hypothesized that perceived housing quality would be significantly greater for those receiving rent assistance compared with those not receiving rent assistance. This hypothesis was also supported. Consistent with AHCS (Adair et al., 2016), PHQ was significantly higher among the HAWS group and there was greater variability in PHQ scores among those not receiving rent assistance, suggesting that HAWS and HF participants demonstrated greater consistency in their quality of housing. The quality of participants' housing was also found to be significantly related to their quality of life, suggesting that the quality of one's living environment can have an impact on their overall well-being (see Appendix J for the correlation matrices).

Recovery outcomes: Transition from street to home. As part of the qualitative interview process, I also asked in what way did having access to HAWS change participants' experiences of housing? The qualitative findings provide further evidence of the impact of rent assistance on housing stability outcomes. HAWS participants who participated in the qualitative interviews were more likely to be housed in their own apartment than those in the non-HAWS condition and therefore were more likely to make the transition from street to home. Participants that were able to make this transition described experiencing choice and control over their living situation, as well as privacy, safety, and self-determination in their new home. These experiences indicate that participants were able to establish a sense of ontological security and individual level empowerment. Factors that facilitated the transition from street to home included program components relating to outreach and financial support, suggesting that rent assistance, in addition to intensive support services, empowers participants to choose housing

that meets their needs, and that acquiring stable independent housing aids in establishing a sense of ontological security.

Secondary outcomes. It was also hypothesized that HAWS participants would show greater improvement than non-HAWS participants on other psychosocial outcomes, including quality of life, social support, community functioning, and food security.

***Quality of life*.** Similar to the findings from the HUD-VASH evaluation (Rosenheck et al., 2003), participants receiving HAWS plus intensive support had greater housing satisfaction and better quality of life outcomes than participants receiving support services only. Whereas HUD-VASH participants only showed improvements in living situation and safety, HAWS participants showed improvements in safety, finances, life overall, and total quality of life. Living situation in the present study was approaching but did not reach a level of statistical significance.

Quality of life results were also comparable at six-months to those found in AHCS, both for ACT (Aubry et al., 2016) and ICM participants (Stergiopoulos et al., 2015). Both HAWS and non-HAWS participants experienced significant improvements in quality of life over time. However, HAWS participants showed greater overall gains on total quality of life scores, living situation, and personal safety. Whereas AHCS study results found HF participants to have significantly greater gains in leisure, the present study found HAWS participants to have significantly greater gains in finances. The effect size for total quality of life score at 12 months was .31 for participants in AHCS, compared to .82 for participants in the present study. It is important to note that gains in quality of life among HF participants in AHCS were greater in the first year of the project. TAU participants showed continued improvements over time, narrowing the gap in quality of life scores by the end of the second year (Aubry et al., 2016;

Stergiopoulos et al., 2015), reinforcing the value of conducting ongoing follow-ups with participants in the current study. Again, direct comparisons to AHCS should be made with caution given that participants in each study received different types of support services.

In sum, allocating housing resources to those considered to be most vulnerable was associated with improvements in housing stability outcomes. These changes reflect a shift at the structural level (i.e., more government funded support towards supported housing programs) and provided opportunities for empowerment at the organizational level (i.e., STEP Home has access to a greater pool of resources to address the needs of participants). STEP Home also aimed to empower participants by giving them more choice over their living situation. This shift in empowerment at the individual level may account for improvements in quality of life. Theories on ontological security also suggest that acquiring a stable home can provide "a platform for re-creating a less stigmatized, normalized life in the present" (Padgett, 2007, p. 12).

Social support, community functioning, and food security. My advisor and I hypothesized that participants receiving rent assistance plus intensive support would show significantly greater gains in social support, community functioning, and food security. Simple effects analysis of informal social support, community functioning, and food security, showed significant improvement over time for HAWS participants, but not for non-HAWS participants. However, no interaction effects were found for these variables. Because of the limitations associated with having a small sample size, these findings are reported as promising trends rather than significant findings and are identified as an important area for future studies to explore.

Data collected on health and social service use showed that the number of non-HAWS participants who reported having seen a health or social service provider increased from 59% to 92%. The average number of times they accessed a community centre also increased from an

average of 68 to 86 times, and the average number of times they accessed a food bank increased from 8 to 21 times. Less noticeable changes were seen among the HAWS group, who reported already being well connected to health and social service providers at baseline (85%). Increases in the amount of contact non-HAWS participants had with health and social service providers may help to explain marginal increases in levels of community functioning, food security, and informal social support among this group. The findings suggest that participants who had access to rent assistance experienced greater improvements on secondary outcome measures. However, an improvement on these measures among those not receiving rent assistance may illustrate the importance of support services and the intensive case management component of a supported housing model.

Recovery outcomes: Transition from home to community and from past to future. Housing was also associated with additional psychosocial outcomes, as identified by those who participated in the qualitative interviews. The transition from home to community and from past to future was more apparent among HAWS compared to non-HAWS participants. Factors associated with the transition from home to community included reconnecting with family, a feeling of social inclusion as a result of having a home like other people, and finding ways to give back or make contributions to the community. Participants in both groups had similar aspirations for the future. However, participants that were not housed were more likely to identify a need to overcome initial barriers, such as securing housing, before being able to move forward. Maintaining negative social contacts was identified in both AHCS and the present study as a factor hindering the ability to make transitions (Macnaughton et al., 2016).

Findings from this study are also in line with AHCS results that looked at positive and negative life trajectories (Nelson et al., 2015). Although individual participants were not coded

according to whether they experienced positive, negative, or mixed life changes, as a group, HAWS participants tended to describe more positive life experiences compared to non-HAWS participants. Similar to the AHCS findings, factors that were associated with positive experiences include housing stability, social support, and a greater sense of hope for the future (Nelson et al., 2015). HAWS participants described experiencing housing stability, improved relationships with family and friends, and better overall health. Outreach support was also associated with positive life experiences in both groups. Like AHCS, factors associated with negative life experiences include housing instability, isolation, negative social contacts, and feelings of hopelessness (Nelson et al., 2015). Non-HAWS participants described experiencing housing instability, lack of social support, and negative feelings about the future. Some negative factors among those housed in HAWS include loneliness and continued financial struggles.

Close relationships and meaningful activities were also identified in another qualitative project as factors associated with positive life changes among participants in a supportive housing program (Padgett et al., 2016). Similarly, HAWS and non-HAWS participants described a desire to get involved in activities that were meaningful to them and identified family as a factor that provided motivation for them to find and secure housing. These findings support Padgett's (2007) argument that housing is only one aspect of recovery. In line with Giddens' concept of ontological security, housing is a base from which participants begin to look forward. Ongoing support is needed as participants continue to develop relationships with others and as they explore and adopt new, meaningful roles in the community.

In summary, the hypothesis that HAWS participants would show greater improvement in housing stability and housing quality outcomes compared with non-HAWS participants was firmly supported. Hypotheses relating to psychosocial outcomes were only partially supported

by the quality of life findings. However, promising trends relating to informal social support, community functioning, and food security were found. Empowerment at the individual level as a result of acquiring stable independent housing and exercising choice over one's living situation may help to explain why those in the HAWS condition showed significantly greater gains in quality of life, and significant improvements in community functioning, food security, and informal social support compared to those in the non-HAWS group who were less likely to be housed. Research with participants housed in a supported housing program suggest that having a home base promotes stability, personal freedom (i.e., from surveillance, to stay away from negative situations or people, and to move towards new opportunities), and identity construction based on valued aspects of one's self (Padgett, 2007), and may also help to explain why HAWS participants experienced significantly greater improvements in quality of life and with respect to other psychosocial outcomes. Significant improvements experienced by non-HAWS participants in quality of life and marginal improvements in community functioning, food security, and informal social support may be related to an increase in contact with health and social service providers. Future evaluations should consider using a larger sample size in order to gain a clearer picture of the impact of rent assistance on secondary outcomes.

Implementation Outcomes

Collecting data on direct support worker insight is valuable when conducting an evaluation of a community-based intervention as it helps to identify factors that help or hinder the implementation process. Support worker findings can be used to shape the ongoing implementation of housing and support services in the community. The following is a discussion of the direct support worker insights as they relate to empowerment theory and previous research.

With the addition of rent assistance, STEP Home is empowered to better meet the housing needs of participants. However, according to direct support worker experiences, there continue to be limitations at the various ecological levels, particularly as they relate to program restrictions, landlord discrimination, and lack of affordable housing. At the program level, flexibility around what is required in order to be eligible for HAWS might be considered in order to meet the unique needs of participants.

At the community level, greater attention directed at building landlord relationships may help to create more opportunities for housing and raise awareness on matters of homelessness and mental illness in the community. Prior research supports the idea that relationships between landlords and participants are important for housing stability outcomes as well as social integration and community living (Kloos et al., 2002). Qualitative research conducted with landlords involved in AHCS show that landlord relationships are essential for creating housing opportunities for participants (Aubry, Cherner et al., 2015). Therefore, maintaining these relationships are a critical component of a HF approach. In building relationships with landlords, it is important to consider incentives for participation. Landlords in AHCS identified the financial component as an incentive for participating; that is, they were more open to housing participants on the condition that rent was guaranteed and the cost of damages was covered. STEP Home direct support workers indicated that they did not have access to a damage fund, making it difficult to persuade landlords to house participants. Landlords from AHCS also appreciated that their needs were responded to promptly. Having a specialized housing support role facilitated this in the HF programs that were part of AHCS. This places less pressure on the case management teams who could provide support to participants without having to enforce

tenancy rules. Direct support workers felt that they would benefit from this in the STEP Home program.

Other incentives to participate in the program were opportunities to give back to the community. Some landlords were also more inclined to participate because of positive experiences with past tenants (Aubry, Cherner et al., 2015). Supporting housing learning among participants also helps to empower them as they navigate landlord/tenancy issues and promotes community integration as they take on normative social roles (MacLeod et al., 2015). Qualitative interviews conducted with landlords in Waterloo region may help to inform ways STEP Home can promote and maintain these relationships in the future.

At the societal level, rent assistance is one approach to making market housing more affordable. However, there continues to be a lack of housing options from which to choose from, indicating a need for continued government-funded support in creating more affordable housing. Recently, the federal government is working on developing a national housing strategy in order to address these issues. Because problems related to housing affordability are the result of an ineffective and disconnected housing system, bringing different jurisdictions together to form a coordinated approach is being recommended (Pomeroy, 2016). Altogether, these represent changes at the program, community, and societal levels, and takes into account structural circumstances that continue to limit housing options for participants (i.e., structuration theory).

As HF programs are implemented in different communities across Canada, an important consideration is how to adapt the model to meet local needs while preserving key aspects of the model that render it effective. Implementation of HF can be particularly challenging when a community already has complex program services in place. Existing models may need to be restructured so that they are more aligned with HF principles. Conducting a mixed methods

evaluation can support the adaptation of a HF model to meet local needs. Qualitative interviews, particularly among key stakeholders, can help to identify factors that impact implementation. The direct support worker focus group helped to identify barriers to implementation including landlord discrimination and lack of affordable housing, factors that were also identified in AHCS (Macnaughton et al., 2012). This process also allowed my advisor and I to identify key aspects of the HF model that might be missing or require adapting, and can point to areas of improvement, such as the need to establish a landlord damage fund. Findings from the focus group can be used to shape the ongoing implementation of a HF approach in Waterloo region. Other communities planning to implement a HF program model should consider conducting focus groups and qualitative interviews with direct support workers and other key stakeholders in order to inform the implementation process.

Limitations

One notable limitation of the present study is that it employs a quasi-experimental design rather than a randomized controlled trial design. This increases the possibility of threats to internal validity, including selection bias, regression to the mean, attrition, and design contamination. Because the selection process was known, my advisor and I were able to control for selection biases. No differences were found between groups on the pre-test measure (VI-SPDAT) or on almost all background characteristics collected at baseline.

Participants in both groups scored high on the VI-SPDAT, indicating high vulnerability. Because HAWS is targeted to those considered to be most at risk, it is possible that participants were more likely to have extreme scores at baseline and regressed toward the mean at follow-up. However, we would expect this to be true for both groups and should therefore not account for treatment differences.

Attrition was slightly higher in the non-HAWS group than in the HAWS group, which could impact study results. Participants who dropped out were significantly more likely to have a mental health diagnosis and to have been born outside of Canada. It is possible that mental health complications made it difficult for participants to participate at follow-up. A similar issue was encountered in the HUD-VASH evaluation. The initial analysis found no differences between groups on substance use over time (Rosenheck et al., 2003). However, a re-analysis of the findings showed that participants who dropped out of the study were more likely to have dropped out as a result of substance use issues, minimizing the results of the original analysis (Cheng et al., 2007). If this is the case in the present study, we might expect results to be even lower for the comparison group.

Because participants were predominantly white and Canadian-born, important information about whether services are culturally sensitive and meet the needs of individuals born outside of Canada is missing. Future research should explore why cultural diversity was underrepresented in the study and why participants born outside of Canada were more likely to drop out.

Lastly, non-HAWS participants were aware that other participants in the study were receiving resources that were not provided to them. It is possible that they responded more negatively as a result of feeling discouraged or according to what they believed was desirable to the interviewer. The present study also had a relatively small sample size and only measured short-term outcomes. Ongoing follow-ups with participants would allow my advisor and I to assess the impacts of the rent assistance program over time.

Conclusion

Overall Contributions

The present study is the first evaluation comparing rent assistance to case management only programs in Canada. The study also builds on HF literature and intentionally incorporates scales used in AHCS to facilitate cross-study comparisons. Similar to AHCS, the current study employed a mixed methods design in order to obtain complementary data on the impact of rent assistance to STEP Home services in Waterloo region. Qualitative data are better able to capture the experiences of participants and provide a human voice to quantitative study results. The study also included total and informal support scales, making it possible to assess whether participants experienced a change in levels of support as a result of acquiring stable independent housing. This component was lacking in AHCS and other research on supported housing programs. Finally, a direct support worker focus group was added to the research design in order to identify barriers and facilitators to implementation. This component of the research is valuable in shaping the ongoing implementation of the rent assistance program and support services in Waterloo region.

Policy Implications

The study results clearly indicate that participants who had access to rent assistance had greater gains in housing stability, perceived housing quality, and quality of life. Participants who were not receiving rent assistance, on the other hand, showed a decline in housing stability, reinforcing the critical role that rent assistance plays in any supported housing program. Since the commencement of the study, Waterloo Region has received funding for an additional 60 rent stipends in order to continue housing those in need. The findings of this study support the enhancement of rent supplements, with the Region moving from 40 to 100 rent supplements for

this population. Given the size of the priority list (around 150 people), my advisor and I recommend that government funded rent stipends be enhanced each year until the priority list for housing is eliminated.

Similar evaluations should also be conducted as HF programs are implemented in communities across Canada. This will help to ensure that programs are meeting the needs of participants in different contexts and will contribute to the pool of literature that can be drawn on to advocate for more government support until issues of homelessness in Canada are resolved. When conducting research for the purpose of policy change, it is important to use rigorous research designs. A mixed method, pretest posttest quasi-experimental design is suitable for research with individuals experiencing homelessness whenever an RCT is not possible as it is non-intrusive and controls for a number of threats to internal validity. Using mixed methods is also valuable as qualitative outcomes can help to shed light on quantitative findings and provide a human voice to the experiences of participants. Finally, the involvement of direct support workers can add an important layer of insight into the types of challenges faced in practice and what changes are needed in order to successfully house and support participants as they become more integrated into society.

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Appendix A.
Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)
Prescreen for Single Adults

GENERAL INFORMATION/CONSENT

Interviewer's Name		Agency ❑ TEAM ❑ STAFF ❑ VOLUNTEER
Date	Time	Location
In what language do you feel best able to express yourself?		
First Name		Last Name
Nickname		Social Security Number
How old are you?	What's your date of birth?	Has Consented to Participate ❑ YES ❑ NO

If 60 years or older, then score 1.	**Prescreen Score**
PRE-SCREEN GENERAL INFORMATION SUBTOTAL	

A. HISTORY OF HOUSING & HOMELESSNESS

QUESTIONS			
If the person has experienced two or more cumulative years of homelessness, and/or 4+ episodes of homelessness, then score 1.	**RESPONSE**	**REFUSED**	**Prescreen Score**
1. What is the total length of time you have lived on the streets or in shelters?		❑	
2. In the past three years, how many times have you been housed and then homeless again?		❑	
PRE-SCREEN HOUSING AND HOMELESSNESS SUBTOTAL			

100,000 HOMES
For 100,000 homeless individuals and families
POWERED BY COMMUNITY SOLUTIONS

ORG CODE

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Prescreen for Single Adults

B. RISKS

SCRIPT: I am going to ask you some questions about your interactions with health and emergency services. If you need any help figuring out when six months ago was, just let me know.

QUESTIONS				
If the total number of interactions across questions 3, 4, 5, 6 and 7 is equal to or greater than 4, then score 1.	RESPONSE		REFUSED	Prescreen Score
3. In the past six months, how many times have you been to the emergency department/room?			❑	
4. In the past six months, how many times have you had an interaction with the police?			❑	
5. In the past six months, how many times have you been taken to the hospital in an ambulance?			❑	
6. In the past six months, how many times have you used a crisis service, including distress centers or suicide prevention hotlines?			❑	
7. In the past six months, how many times have you been hospitalized as an in-patient, including hospitalizations in a mental health hospital?			❑	
If YES to questions 8 or 9, then score 1.	YES	NO	REFUSED	Prescreen Score
8. Have you been attacked or beaten up since becoming homeless?	❑	❑	❑	
9. Threatened to or tried to harm yourself or anyone else in the last year?	❑	❑	❑	
If YES to question 10, then score 1.	YES	NO	REFUSED	Prescreen Score
10. Do you have any legal stuff going on right now that may result in you being locked up or having to pay fines?	❑	❑	❑	
If YES to questions 11 or 12; OR if respondent provides any answer *OTHER THAN* "Shelter" in question 13, then score 1.	YES	NO	REFUSED	Prescreen Score
11. Does anybody force or trick you to do things that you do not want to do?	❑	❑	❑	
12. Ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone you don't really know, share a needle, or anything like that?	❑	❑	❑	
13. I am going to read types of places people sleep. Please tell me which one that you sleep at most often. (Check only one.)	❑ Shelter ❑ Street, Sidewalk or Doorway ❑ Car, Van or RV ❑ Bus or Subway ❑ Beach, Riverbed or Park ❑ Other (SPECIFY):			
PRE-SCREEN RISKS SUBTOTAL				

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)
Prescreen for Single Adults

C. SOCIALIZATION & DAILY FUNCTIONS

QUESTIONS				
If YES to question 14 or NO to questions 15 or 16, score 1.	YES	NO	REFUSED	Prescreen Score
14. Is there anybody that thinks you owe them money?	❑	❑	❑	
15. Do you have any money coming in on a regular basis, like a job or government benefit or even working under the table, binning or bottle collecting, sex work, odd jobs, day labor, or anything like that?	❑	❑	❑	
16. Do you have enough money to meet all of your expenses on a monthly basis?	❑	❑	❑	
If NO to question 17, score 1.	YES	NO	REFUSED	Prescreen Score
17. Do you have planned activities each day other than just surviving that bring you happiness and fulfillment?	❑	❑	❑	
If YES to questions 18 or 19, score 1.	YES	NO	REFUSED	Prescreen Score
18. Do you have any friends, family or other people in your life out of convenience or necessity, but you do not like their company?	❑	❑	❑	
19. Do any friends, family or other people in your life ever take your money, borrow cigarettes, use your drugs, drink your alcohol, or get you to do things you really don't want to do?	❑	❑	❑	
OBSERVE ONLY. DO NOT ASK! If YES, score 1.	YES	NO		Prescreen Score
20. Surveyor, do you detect signs of poor hygiene or daily living skills?	❑	❑		
PRE-SCREEN SOCIALIZATION & DAILY FUNCTIONS SUBTOTAL				

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)
Prescreen for Single Adults

OBSERVATION ONLY – DO NOT ASK: 41. Surveyor, do you observe signs or symptoms or problematic alcohol or drug abuse?	❑	❑		
If any response is YES in questions 42 through 48, score 1 in the Mental Health Column.	**YES**	**NO**	**REFUSED**	**Mental Health**
42. Ever been taken to a hospital against your will for a mental health reason?	❑	❑	❑	
43. Gone to the emergency room because you weren't feeling 100% well emotionally or because of your nerves?	❑	❑	❑	
44. Spoken with a psychiatrist, psychologist or other mental health professional in the last six months because of your mental health – whether that was voluntary or because someone insisted that you do so?	❑	❑	❑	
45. Had a serious brain injury or head trauma?	❑	❑	❑	
46. Ever been told you have a learning disability or developmental disability?	❑	❑	❑	
47. Do you have any problems concentrating and/or remembering things?	❑	❑	❑	
OBSERVATION ONLY – DO NOT ASK: 48. Surveyor, do you detect signs or symptoms of severe, persistent mental illness or severely compromised cognitive functioning?	❑	❑		
If the Substance Use score is 1 AND the Mental Health score is 1 AND the Medical Condition score is at least a 1 OR an X, then score 1 additional point for tri-morbidity.				**Tri-Morbidity**
If YES to question 49, score 1.	**YES**	**NO**	**REFUSED**	**Prescreen Score**
49. Have you had any medicines prescribed to you by a doctor that you do not take, sell, had stolen, misplaced, or where the prescriptions were never filled?	❑	❑	❑	
If YES to question 50, score 1.	**YES**	**NO**	**REFUSED**	**Prescreen Score**
50. Yes or No – Have you experienced any emotional, physical, psychological, sexual or other type of abuse or trauma in your life which you have not sought help for, and/or which has caused your homelessness?	❑	❑	❑	
PRE-SCREEN WELLNESS SUBTOTAL				

SCORING SUMMARY

DOMAIN	SUBTOTAL
GENERAL INFORMATION	
A. HISTORY OF HOUSING AND HOMELESSNESS	
B. RISKS	
C. SOCIALIZATION AND DAILY FUNCTIONS	
D. WELLNESS	
PRE-SCREEN TOTAL	

If the Pre-Screen Total is equal to or greater than 10, the individual is recommended for a Permanent Supportive Housing/Housing First Assessment.

If the Pre-Screen Total is 5, 6, 7, 8 or 9, the individual is recommended for a Rapid Re-Housing Assessment.

If the Pre-Screen Total is 0, 1, 2, 3 or 4, the individual is not recommended for a Housing and Support Assessment at this time.

100,000 HOMES
For 100,000 homeless individuals and families
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ORG CODE

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)

Prescreen for Single Adults

Finally I'd like to ask you some questions to help us better understand homelessness and improve housing and support services.

What is your gender?	❑ Male ❑ Female ❑ Transgender ❑ Other ❑ Decline to State
Have you ever served in the US Military?	❑ Yes ❑ No ❑ Refused
If yes, which war/war era did you serve in?	❑ Korean War (June 1950-January 1955) ❑ Vietnam Era (August 1964-April 1975) ❑ Post Vietnam (May 1975-July 1991) ❑ Persian Gulf Era (August 1991-Present) ❑ Afghanistan (2001-Present) ❑ Iraq (2003-Present) ❑ Other (Specify) ❑ Refused
If yes, what was the character of your discharge?	❑ Honorable ❑ Other than Honorable ❑ Bad Conduct ❑ Dishonorable ❑ Refused
What is your citizenship status?	❑ Citizen ❑ Legal Resident ❑ Undocumented ❑ Refused
Where did you live prior to becoming homeless?	❑ This city ❑ This region ❑ Other part of the State ❑ Somewhere else (specify)_____
Have you ever been in foster care?	❑ Yes ❑ No ❑ Refused
Have you ever been in jail?	❑ Yes ❑ No ❑ Refused
Have you ever been in prison?	❑ Yes ❑ No ❑ Refused
Do you have a permanent physical disability that limits your mobility? [i.e., wheelchair, amputation, unable to climb stairs]?	❑ Yes ❑ No ❑ Refused
What kind of health insurance do you have, if any? (check all that apply)	❑ Medicaid ❑ Medicare ❑ VA ❑ Private Insurance ❑ None ❑ Other (specify): _____
On a regular day, where is it easiest to find you and what time of day is easiest to do so?	
Is there a phone number and/or email where someone can get in touch with you or leave you a message?	
Ok, now I'd like to take your picture. May I do so?	❑ Yes ❑ No ❑ Refused

Appendix B. Recruitment Letter

WILFRID LAURIER UNIVERSITY
Recruitment Letter

Waterloo Region STEP Home Housing First Pilot Study
Principal Investigators: Courtney Pankratz, M.A. Student, Geoffrey Nelson, Ph.D.
Department of Psychology

Dear STEP Home Worker,

You are receiving this letter as a Direct Support Worker in a STEP Home program. We are writing to ask for your assistance in recruiting participants for a STEP Home study.

The Region of Waterloo is interested in evaluating the effectiveness of the addition of rent assistance to housing and support services in the Waterloo region. The research findings will be used to advocate for more funding towards rent assistance and to inform best practices within the region.

The Region of Waterloo has obtained funding for rent assistance that will help to provide housing for 40 people with housing needs. Rent assistance is an important component of any supported housing model as it provides people with the means to afford housing, generating more choice and control over one's living arrangement. Allocation of rent assistance was determined based on the Vulnerability Index – Service Prioritization Decision Assistance Prescreen Tool (VI-SPDAT), in addition to support worker knowledge, such that those identified as being the most vulnerable were selected to receive the rent assistance.

In this research, we will be comparing the effectiveness of the addition of rent assistance to existing housing and support services for people experiencing persistent homelessness to regular services available in the Waterloo Region. The researchers will study a group of 60 adults (i.e., 16+ years of age) living in Waterloo Region. This group will consist of 40 people who were selected to receive rent assistance and 20 who were not.

Participation in the study is voluntary and a participant will have the option to withdraw from the study at anytime. Participation in the study will not impact whether or not a person receives rent assistance. Participation in the study will involve an interview at baseline and a follow-up interview 6 months later. The interviews will consist of several questions related to housing history, physical health, mental health, health and social services you use, quality of life, and personal characteristics such as age, education background, marital status, and income. Peer researchers with lived experience of homelessness will conduct the interviews along with Ms. Courtney Pankratz, who is a graduate student in the Community Psychology M.A. program at Wilfrid Laurier University. Participants will be compensated for their time – a $20 gift card for the first interview and $25 gift card for the second interview.

This letter is a request for assistance in the recruitment of participants. In order for the research to move forward, the researchers need to obtain permission to contact interested candidates, as well as permission to obtain their scores on the VI-SPDAT.

It would be of great help to the researchers if information about the study could be communicated to those who fit the eligibility requirements (a list of eligible candidates will be provided by the Region of Waterloo). The consent form for participants is attached to this email.

If you have any questions about the study, you can contact the researchers whose information is provided below:

Courtney Pankratz
Email: pank4560@mylaurier.ca
Phone Number: 519-884-0710 Ext. 4251

Dr. Geoff Nelson, PhD
E-MAIL: gnelson@wlu.ca
TEL: (519) 884-0710 ext. 3314

Your assistance in the recruitment process is greatly appreciated.

Sincerely,
Courtney Pankratz

Appendix C. Baseline Consent Form

You are invited to participate in a research study in your community!

Here is a quick overview of what the research is about…

A dedicated team of support workers, community organizations, and researchers are conducting a study that will help to advocate for more funding towards rent assistance in the Waterloo region.

What is Housing First?

Housing First is a consumer-driven approach that provides immediate access to permanent housing by providing rent assistance, in addition to flexible, community-based services for people who have experienced homelessness.

What are you being asked to do in this research?

We are asking individuals experiencing homelessness to participate in two 1-hr interviews conducted by one of our peer researchers.

You will receive $30 in gift cards for participating in the first interview, and $35 in gift cards for the second interview.!

Here are some types of questions that will be asked during the interview:

- Your education, marital status, and employment!
- Your housing history!
- Your physical and mental health!
- The health and social services you use!
- How you feel about your housing!
- Relationships and social support!
- How you feel about your life overall!
- Life events and personal changes!

Interested in participating or want more information?
See the full consent form…

!

WILFRID LAURIER UNIVERSITY
Baseline Informed Consent Form

Waterloo Region STEP Home Housing First Pilot Study!!

Principal Investigators: Courtney Pankratz, M.A. Student, Geoffrey Nelson, Ph.D.
Department of Psychology

!

You are invited to participate in a research study. The purpose of this study is to evaluate the effectiveness of the addition of rent assistance to housing and support services in the Waterloo region. The research findings will be used to advocate for more funding towards rent assistance and to inform best practices within the region. If you would like to participate, please sign the back page of this form and return it to your direct support worker. Please keep this Informed Consent Statement for project information and future reference.

What is this Study All About?

Rent assistance is an important component of any supported housing model as it provides people with the means to afford housing, generating more choice and control over one's living arrangement. In this research, we will be comparing the effectiveness of the addition of rent assistance to existing housing and support services for people experiencing persistent homelessness to regular services available in the Waterloo Region. The researchers will study a group of 60 adults (i.e., 16+ years of age) living in Waterloo Region. This group will consist of 40 people who have received a rent assistance and 20 who have not.

What Will I be Asked to Do?

Participation in this study will involve (1) the release of your score on the Vulnerability Index – Service Prioritization Decision Assistance Prescreen Tool (VI-SPDAT) from the Region of Waterloo, (2) participation in a 60-75 minute interview with the researchers at the beginning of the study, and (3) participation in a second 60-75 minute interview with the researchers 6 months later for a total time commitment of 120-150 minutes (the second interview will be audio-recorded). The interviews will consist of several questions related to housing history, physical health, mental health, health and social services use, quality of life, and personal characteristics such as age, education background, marital status, and income. The interviews will be conducted by a member of the research team (i.e., Courtney Pankratz, Dr. Geoffrey Nelson, Farah Lahens, Garry Hauke.).

Will I Receive any Compensation for Participating?

If you are found to be eligible to participate in the study, you will receive $30 in gift cards for the initial baseline interview and $35 in gift cards for the follow-up interview at 6 months. If a participant withdraws during the first interview, they will still receive $30 in gift cards. Similarly, if a participant withdraws during the second interview, they will still receive $35 in gift cards in compensation.

Do I Have to Participate?

You have the right to decide that you do not want to take part in the research. Your decision to take part or to not take part will in no way affect any of the services you receive now or in the future. You may withdraw from the study at any time, even after signing the attached consent form. If there are any parts of the research that you are uncomfortable with, please inform the researcher. The researcher will welcome your participation in the parts of the research with which you are comfortable.

If you decide to participate, you have the right to skip any question or procedure you choose, or withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled. If you begin the study, but withdraw prior to completion, your data will be destroyed.

Are There Any Risks to Me as a Participant?

It is possible that some participants may experience mild discomfort associated with self-disclosure of information on their health status, functioning, and quality of life. However, we expect this discomfort to be low level and transient in nature. These feelings are normal and should be temporary. If you experience any lasting negative feelings as a result of participating in this study, please contact the researchers and/or your direct support worker.

Are There any Benefits to Myself and Others?

The information collected during the study will be used to help us understand whether or not the new services being studied are effective in assisting people who are having housing difficulties. This should assist local planning of housing and services, government policies, and the scientific community about how to best serve people with housing challenges.

Is the Information I Share Kept Confidential?

Confidentiality will be respected and no information that discloses your identity will be released or published without consent unless required by law, such as disclosing abuse, the presence of acute risk of harm to yourself or others, or because of a court order. If there is perceived risk, privacy will be breached and you will be asked/made to seek care. Because participation in the study requires the Region of Waterloo to release VI-SPDAT scores to the researchers, privileged staff at the Region will know who has consented to participate. However, staff at the Region of Waterloo will be required to keep this information confidential.

Only Courtney Pankratz and Dr. Geoff Nelson will have access to the data. (Please note that interviewers will temporarily have access to the data collected from participants.) All data collected in this study will be stored in a locked office at Wilfrid Laurier University, with electronic data stored on a password-protected computer and hardcopy data stored in a locked cabinet. Data collected during the interviews will initially be stored in a locked box at DCHC, until the researcher collects the documents and transfers them to her office. Identifiable information will be stored separate from the data and will be destroyed by the researchers by June 30, 2016. De-identified data will be destroyed by Dr. Geoff Nelson by June 30, 2026.

CONSENT
Participant Copy

I have read and understand the information in this form, and have been given a copy to keep for my records. I acknowledge that the research study described above has been explained to me and that any questions that I have asked have been answered to my satisfaction. I have been informed of my right to choose to not participate in the study. As well, the potential risks, harms and discomforts have been explained to me and I also understand the benefits of participating in the research study. I understand that I have not waived my legal rights nor released the investigators, sponsors, or involved institutions from their legal and professional duties. I know that I may ask now or in the future any questions I have about the study or the research procedures. I have been assured that information relating to me will be kept confidential and that no information will be released or printed that would disclose my personal identity without my permission unless required by law. I have been given sufficient time to read and understand the above information.

If you choose to participate in this study, please complete the following:

I agree to allow the researchers named above to access my VI-SPDAT score, which is being kept by the Region of Waterloo. **(Check if agree.)**

I agree to allow the researchers named above to contact me or the people/agencies listed on this form for the purposes of contacting me about participation in the research. **(Check if agree)**

I agree to participate in the baseline interview. **(Check if agree.)**

_____	_____	_____
Signature of Participant	Name (printed)	Date
_____	_____	_____
Signature of Researcher	Name (printed)	Date

Check to indicate your interest in receiving a summary of the results.
The researchers will send a copy of the summary to the email address provided.

Where Will the Results of this Study be Published? How Can I Access a Summary of the Results?

By September 2016, a summary of the findings of the research will be made available in hard copy at participating social service agencies. The findings will also be shared with the Director of Homelessness Prevention at the Region of Waterloo and her staff, who will be encouraged to circulate any reports that come out of the research to interested community organizations. If you are interesting in receiving a summary of the results, please provide us with an email for you on the next page.

The results will be included in Ms. Courtney Pankratz's MA thesis. It is also possible that results may be used to prepare articles for academic journals or presentations for academic conferences, however this will be determined later in the research. In the event that the results of this study are published or presented at conferences, seminars or other public forums, no individual information or information that could identify you will be included. If and when quotes are used, the content will not allow for your identification.

Who Can I Contact if I Have Questions or Concerns?

If you have questions at any time about the study or the procedures, (or you experience adverse effects as a result of participating in this study) you may contact the researchers whose information is provided below:

Courtney Pankratz, M.A. Candidate
Wilfrid Laurier University, Science Building, 75 University Ave. W., Waterloo, ON N2L 3C5 E-MAIL: pank4560@mylaurier.ca TEL: (519) 884-0710 ext. 4251

Dr. Geoff Nelson, PhD
Wilfrid Laurier University, N2075F, Science Building, 75 University Ave. W., Waterloo, ON N2L 3C5 E-MAIL: gnelson@wlu.ca TEL: (519) 884-0710 ext. 3314

This project has been reviewed and approved by the Wilfrid Laurier University Research Ethics Board (REB #4357). If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Dr. Robert Basso at the Research Ethics Office at Wilfrid Laurier University by phone at (519) 884-0710 ext. 4994 or by email at rbasso@wlu.ca.

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CONSENT
Researcher Copy

I have read and understand the information in this form, and have been given a copy to keep for my records. I acknowledge that the research study described above has been explained to me and that any questions that I have asked have been answered to my satisfaction. I have been informed of my right to choose to not participate in the study. As well, the potential risks, harms and discomforts have been explained to me and I also understand the benefits of participating in the research study. I understand that I have not waived my legal rights nor released the investigators, sponsors, or involved institutions from their legal and professional duties. I know that I may ask now or in the future any questions I have about the study or the research procedures. I have been assured that information relating to me will be kept confidential and that no information will be released or printed that would disclose my personal identity without my permission unless required by law. I have been given sufficient time to read and understand the above information.

If you choose to participate in this study, please complete the following:

I agree to allow the researchers named above to access my VI-SPDAT score, which is being kept by the Region of Waterloo. **(Check if agree.)**

I agree to allow the researchers named above to contact me or the people/agencies listed on this form for the purposes of contacting me about participation in the research. **(Check if agree)**

I agree to participate in the baseline interview. **(Check if agree.)**

_____	_____	_____
Signature of Participant	Name (printed)	Date
_____	_____	_____
Signature of Researcher	Name (printed)	Date

Check to indicate your interest in receiving a summary of the results.
The researchers will send a copy of the summary to the email address provided.

PARTICIPANT CONTACT INFORMATION:

Your Primary Contact Information:

Preferred Name:
_____

Phone (1):
_____

Phone (2):
_____

Email:
_____

Other:
_____

Preferred method of contact:
_____

Alternative Contact Information (1):

Name/Agency:
_____

Relationship to you:
_____

Phone:
_____

Email:
_____

Alternative Contact Information (2):

Name/Agency:
_____

Relationship to you:
_____

Phone:
_____

Email:
_____

Appendix D.
Follow Up Consent Form – Quantitative Interview Only

WILFRID LAURIER UNIVERSITY
Follow-up Interview Informed Consent Statement

Waterloo Region STEP Home Housing First Pilot Study
Principal Investigators: Courtney Pankratz, M.A. Student, Geoffrey Nelson, Ph.D.
Department of Psychology

You are invited to participate in a research study. The purpose of this study is to evaluate the effectiveness of the addition of rent assistance to housing and support services in the Waterloo region. The research findings will be used to advocate for more funding towards rent assistance and to inform best practices within the region. If you would like to participate, please sign the back page of this form and return it to your direct support worker. Please keep this Informed Consent Statement for project information and future reference.

In this consent form, we are asking for your consent to participate in the follow-up interview.

What is this Study All About?

Rent assistance is an important component of any supported housing model as it provides people with the means to afford housing, generating more choice and control over one's living arrangement. In this research, we will be comparing the effectiveness of the addition of rent assistance to existing housing and support services for people experiencing persistent homelessness to regular services available in the Waterloo Region. The researchers will study a group of 60 adults (i.e., 16+ years of age) living in Waterloo Region. This group will consist of 40 people who have received a rent assistance and 20 who have not.

What Will I be Asked to Do?

Participation in this study will involve (1) the release of your score on the Vulnerability Index – Service Prioritization Decision Assistance Prescreen Tool (VI-SPDAT) from the Region of Waterloo, (2) participation in a 60-75 minute interview with the researchers at the beginning of the study, and (3) participation in a second 60-75 minute interview with the researchers 6 months later for a total time commitment of 120-150 minutes (the second interview will be audio-recorded). The interviews will consist of several questions related to housing history, physical health, mental health, health and social services use, quality of life, and personal characteristics such as age, education background, marital status, and income. The interviews will be conducted by a member of the research team (i.e., Courtney Pankratz, Farah Lahens, Garry Hauke, Jeremy Megit.).

In this interview, you will be asked in more detail about your housing history, physical health, mental health, support you receive from other people in your life, health and social services you use, and quality of life as well as some open-ended questions that focus on your experiences of homelessness and other difficulties you may have encountered.

Will I Receive any Compensation for Participating?

If you are found to be eligible to participate in the study, you will receive $30 in gift cards for the initial baseline interview and $35 in gift cards for the follow-up interview at 6 months. If a participant withdraws during the first interview, they will still receive $30 in gift cards. Similarly, if a participant withdraws during the second interview, they will still receive $35 in gift cards in compensation.

Do I Have to Participate?

You have the right to decide that you do not want to take part in the research. Your decision to take part or to not take part will in no way affect any of the services you receive now or in the future. You may withdraw from the study at any time, even after signing the attached consent form. If there are any parts of the research that you are uncomfortable with, please inform the researcher. The researcher will welcome your participation in the parts of the research with which you are comfortable.

If you decide to participate, you have the right to skip any question or procedure you choose, or withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled. If you begin the study, but withdraw prior to completion, your data will be destroyed.

Are There Any Risks to Me as a Participant?

It is possible that some participants may experience mild discomfort associated with self-disclosure of information on their health status, functioning, and quality of life. However, we expect this discomfort to be low level and transient in nature. These feelings are normal and should be temporary. If you experience any lasting negative feelings as a result of participating in this study, please contact the researchers and/or your direct support worker.

Are There any Benefits to Myself and Others?

The information collected during the study will be used to help us understand whether or not the new services being studied are effective in assisting people who are having housing difficulties. This should assist local planning of housing and services, government policies, and the scientific community about how to best serve people with housing challenges.

Is the Information I Share Kept Confidential?

Confidentiality will be respected and no information that discloses your identity will be released or published without consent unless required by law, such as disclosing abuse, the presence of acute risk of harm to yourself or others, or because of a court order. If there is perceived risk, privacy will be breached and you will be asked/made to seek care. Because participation in the study requires the Region of Waterloo to release VI-SPDAT scores to the researchers, privileged staff at the Region will know who has consented to participate. However, staff at the Region of Waterloo will be required to keep this information confidential.

Only Courtney Pankratz and Dr. Geoff Nelson will have access to the data. (Please note that interviewers will temporarily have access to the data collected from participants.) All data collected in this study will be stored in a locked office at Wilfrid Laurier University, with electronic data stored on a password-protected computer and hardcopy data stored in a locked

cabinet. Data collected during the interviews will initially be stored in a locked box at DCHC, until the researcher collects the documents and transfers them to her office. Identifiable information will be stored separate from the data and will be destroyed by the researchers by June 30, 2016. De-identified data will be destroyed by Dr. Geoff Nelson by June 30, 2026.

Where Will the Results of this Study be Published? How Can I Access a Summary of the Results?

By September 2016, a summary of the findings of the research will be made available in hard copy at participating social service agencies. The findings will also be shared with the Director of Homelessness Prevention at the Region of Waterloo and her staff, who will be encouraged to circulate any reports that come out of the research to interested community organizations. A summary of the results will be sent to individuals who have indicated interest in receiving a copy by email.

The results will be included in Ms. Courtney Pankratz's MA thesis. It is also possible that results may be used to prepare articles for academic journals or presentations for academic conferences, however this will be determined later in the research. In the event that the results of this study are published or presented at conferences, seminars or other public forums, no individual information or information that could identify you will be included. If and when quotes are used, the content will not allow for your identification.

Who Can I Contact if I Have Questions or Concerns?

If you have questions at any time about the study or the procedures, (or you experience adverse effects as a result of participating in this study) you may contact the researchers whose information is provided below:

Courtney Pankratz, M.A. Candidate
Wilfrid Laurier University, Science Building, 75 University Ave. W., Waterloo, ON N2L 3C5 E-MAIL: pank4560@mylaurier.ca TEL: (519) 884-0710 ext. 4251

Dr. Geoff Nelson, PhD
Wilfrid Laurier University, N2075F, Science Building, 75 University Ave. W., Waterloo, ON N2L 3C5 E-MAIL: gnelson@wlu.ca TEL: (519) 884-0710 ext. 3314

This project has been reviewed and approved by the Wilfrid Laurier University Research Ethics Board (REB #4357). If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Dr. Robert Basso at the Research Ethics Office at Wilfrid Laurier University by phone at (519) 884-0710 ext. 4994 or by email at rbasso@wlu.ca.

CONSENT
Participant Copy

I have read and understand the information in this form, and have been given a copy to keep for my records. I acknowledge that the research study described above has been explained to me and that any questions that I have asked have been answered to my satisfaction. I have been informed of my right to choose to not participate in the study. As well, the potential risks, harms and discomforts have been explained to me and I also understand the benefits of participating in the research study. I understand that I have not waived my legal rights nor released the investigators, sponsors, or involved institutions from their legal and professional duties. I know that I may ask now or in the future any questions I have about the study or the research procedures. I have been assured that information relating to me will be kept confidential and that no information will be released or printed that would disclose my personal identity without my permission unless required by law. I have been given sufficient time to read and understand the above information.

If you choose to participate in this study, please complete the following:

I agree to participate in the follow-up interview. **(Check if agree.)**

_____	_____	_____
Signature of Participant	Name (printed)	Date
_____	_____	_____
Signature of Researcher	Name (printed)	Date

CONSENT
Researcher Copy

I have read and understand the information in this form, and have been given a copy to keep for my records. I acknowledge that the research study described above has been explained to me and that any questions that I have asked have been answered to my satisfaction. I have been informed of my right to choose to not participate in the study. As well, the potential risks, harms and discomforts have been explained to me and I also understand the benefits of participating in the research study. I understand that I have not waived my legal rights nor released the investigators, sponsors, or involved institutions from their legal and professional duties. I know that I may ask now or in the future any questions I have about the study or the research procedures. I have been assured that information relating to me will be kept confidential and that no information will be released or printed that would disclose my personal identity without my permission unless required by law. I have been given sufficient time to read and understand the above information.

If you choose to participate in this study, please complete the following:

I agree to participate in the follow-up interview. **(Check if agree.)**

_____	_____	_____
Signature of Participant	Name (printed)	Date
_____	_____	_____
Signature of Researcher	Name (printed)	Date

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Appendix E.
Follow Up Consent Form – Quantitative and Qualitative Interview

WILFRID LAURIER UNIVERSITY
Follow-up Interview Informed Consent Statement

Waterloo Region STEP Home Housing First Pilot Study
Principal Investigators: Courtney Pankratz, M.A. Student, Geoffrey Nelson, Ph.D.
Department of Psychology

You are invited to participate in a research study. The purpose of this study is to evaluate the effectiveness of the addition of rent assistance to housing and support services in the Waterloo region. The research findings will be used to advocate for more funding towards rent assistance and to inform best practices within the region. If you would like to participate, please sign the back page of this form and return it to your direct support worker. Please keep this Informed Consent Statement for project information and future reference.

In this consent form, we are asking for your consent to participate in the follow-up interview. Part of this interview will be audio-recorded.

What is this Study All About?

Rent assistance is an important component of any supported housing model as it provides people with the means to afford housing, generating more choice and control over one's living arrangement. In this research, we will be comparing the effectiveness of the addition of rent assistance to existing housing and support services for people experiencing persistent homelessness to regular services available in the Waterloo Region. The researchers will study a group of 60 adults (i.e., 16+ years of age) living in Waterloo Region. This group will consist of 40 people who have received a rent assistance and 20 who have not.

What Will I be Asked to Do?

Participation in this study will involve (1) the release of your score on the Vulnerability Index – Service Prioritization Decision Assistance Prescreen Tool (VI-SPDAT) from the Region of Waterloo, (2) participation in a 60-75 minute interview with the researchers at the beginning of the study, and (3) participation in a second 60-75 minute interview with the researchers 6 months later for a total time commitment of 120-150 minutes (the second interview will be audio-recorded). The interviews will consist of several questions related to housing history, physical health, mental health, health and social services use, quality of life, and personal characteristics such as age, education background, marital status, and income. The interviews will be conducted by a member of the research team (i.e., Courtney Pankratz, Farah Lahens, Garry Hauke, Jeremy Megit.).

In this interview, you will be asked in more detail about your housing history, physical health, mental health, support you receive from other people in your life, health and social services you use, and quality of life as well as some open-ended questions that focus on your experiences of homelessness and other difficulties you may have encountered.

Will I Receive any Compensation for Participating?

If you are found to be eligible to participate in the study, you will receive $30 in gift cards for the initial baseline interview and $35 in gift cards for the follow-up interview at 6 months. If a participant withdraws during the first interview, they will still receive $30 in gift cards. Similarly, if a participant withdraws during the second interview, they will still receive $35 in gift cards in compensation.

Do I Have to Participate?

You have the right to decide that you do not want to take part in the research. Your decision to take part or to not take part will in no way affect any of the services you receive now or in the future. You may withdraw from the study at any time, even after signing the attached consent form. If there are any parts of the research that you are uncomfortable with, please inform the researcher. The researcher will welcome your participation in the parts of the research with which you are comfortable.

If you decide to participate, you have the right to skip any question or procedure you choose, or withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled. If you begin the study, but withdraw prior to completion, your data will be destroyed.

Are There Any Risks to Me as a Participant?

It is possible that some participants may experience mild discomfort associated with self-disclosure of information on their health status, functioning, and quality of life. However, we expect this discomfort to be low level and transient in nature. These feelings are normal and should be temporary. If you experience any lasting negative feelings as a result of participating in this study, please contact the researchers and/or your direct support worker.

Are There any Benefits to Myself and Others?

The information collected during the study will be used to help us understand whether or not the new services being studied are effective in assisting people who are having housing difficulties. This should assist local planning of housing and services, government policies, and the scientific community about how to best serve people with housing challenges.

Is the Information I Share Kept Confidential?

Confidentiality will be respected and no information that discloses your identity will be released or published without consent unless required by law, such as disclosing abuse, the presence of acute risk of harm to yourself or others, or because of a court order. If there is perceived risk, privacy will be breached and you will be asked/made to seek care. Because participation in the study requires the Region of Waterloo to release VI-SPDAT scores to the researchers, privileged staff at the Region will know who has consented to participate. However, staff at the Region of Waterloo will be required to keep this information confidential.

Only Courtney Pankratz and Dr. Geoff Nelson will have access to the data. (Please note that interviewers will temporarily have access to the data collected from participants.) All data collected in this study will be stored in a locked office at Wilfrid Laurier University, with electronic data stored on a password-protected computer and hardcopy data stored in a locked

cabinet. Data collected during the interviews will initially be stored in a locked box at DCHC, until the researcher collects the documents and transfers them to her office. Identifiable information will be stored separate from the data and will be destroyed by the researchers by June 30, 2016. De-identified data will be destroyed by Dr. Geoff Nelson by June 30, 2026.

Where Will the Results of this Study be Published? How Can I Access a Summary of the Results?

By September 2016, a summary of the findings of the research will be made available in hard copy at participating social service agencies. The findings will also be shared with the Director of Homelessness Prevention at the Region of Waterloo and her staff, who will be encouraged to circulate any reports that come out of the research to interested community organizations. A summary of the results will be sent to individuals who have indicated interest in receiving a copy by email.

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CONSENT
Participant Copy

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If you choose to participate in this study, please complete the following:

I agree to participate in the follow-up interview. **(Check if agree.)**

The researchers may want to use your quotations in publications and presentations that result from this research. Please check ONE of the following with respect to the use of your quotations:

I agree to allow the researchers to use my de-identified quotations with the understanding that they will remove any personal information from my quotations before they are used.

I agree to allow the researchers to use my de-identified quotations ONLY after I have had the chance to review the quotations that they intend to use. (If you choose this option, the researcher will contact you using the contact information provided to arrange a time and place to meet for this purpose.)

I DO NOT allow the researchers to use my de-identified quotations.

Signature of Participant	Name (printed)	Date
Signature of Researcher	Name (printed)	Date

CONSENT
Researcher Copy

I have read and understand the information in this form, and have been given a copy to keep for my records. I acknowledge that the research study described above has been explained to me and that any questions that I have asked have been answered to my satisfaction. I have been informed of my right to choose to not participate in the study. As well, the potential risks, harms and discomforts have been explained to me and I also understand the benefits of participating in the research study. I understand that I have not waived my legal rights nor released the investigators, sponsors, or involved institutions from their legal and professional duties. I know that I may ask now or in the future any questions I have about the study or the research procedures. I have been assured that information relating to me will be kept confidential and that no information will be released or printed that would disclose my personal identity without my permission unless required by law. I have been given sufficient time to read and understand the above information.

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I DO NOT allow the researchers to use my de-identified quotations.

Signature of Participant	Name (printed)	Date
Signature of Researcher	Name (printed)	Date

Appendix F. Baseline Interview

Participant ID: _____ Date of Interview: M ____ D____Y_____

Demographics, Service & Housing History

Now I'll start with the interview questions. First some about your gender, where you were born, and your background.

1.	How do you identify your gender?	□Male □Female □Transgender □Transexual □Declined □Other: _____
2.	Where were you born, that is, what country?	□Don't Know □Declined
3.	What is your ethnic or cultural identity?	□Don't Know □Declined
3.a	If Aboriginal, are you (check all the apply): **IF does not identify as Aboriginal, SKIP to question 4**	□Inuit □First Nations Status □Indigenous from outside Canada □Metis □First Nations Non-status □Other: _____
4.	Not counting kindergarten, how many years of school did you complete? Can include a range. E.g. between 5-8 years	Number of years: _____
5.	What is your level of education?	□Completed grade 4 or less □Completed grade 5 to 8 □Attended High School (not completed) □Completed High School □Attended business, trade, technical school □Completed business, trade, technical school □Attended University, not completed □Completed University (Bachelor's degree) □Completed Graduate School □Don't Know □Declined
6.	Are you currently single?	□Single, never married □Married □Separated □Divorced □Cohabitating with a partner □Widowed □Don't Know □Declined
7.	How many children do you have under the age of 18? Include whether or not they live with you. **IF no children under 18, SKIP to question 8**	□Number of children: _____ □Don't Know □Declined
7.a	How many of these children do you currently provide full or partial support to?	

Participant ID: _____ Date of Interview: M ____ D____Y_____

Thanks for all your answers so far. We have only about 10 questions left in this section; some of these last questions can be quite personal sometimes, but they are important to ask at the beginning so that we will be able to see how things might change for people as the study goes along.

8.	Have you worked continuously for at least one year in the past?	□Yes □No □Don't Know □Declined
17.	In the past 6 months, have you been arrested for criminal activity more than once, or been imprisoned at least once, or served probation or other community sanction?	□Yes □No □Don't Know □Declined
9.	Have you ever had any wartime service in the military forces of Canada or its allies?	□Yes □No □Don't Know □Declined
18.	In the past 6 months, did you spend one or more nights in a hospital, detox centre, jail, or shelter? **IF NO, SKIP to question 20**	□Yes □No □Don't Know □Declined
	What is the name of the place you stayed at most recently?	**Name of location:** _____
	Approximately how many days were you in [location name]? If participant stayed more than one time in this location, enter total days in past 6 months.	**Number of days**: _____
19.	And for the stay before that, what is the name of the hospital, detox centre, jail, or shelter?	**Name of location:** _____
	Approximately how many days were you in [location name]? If participant stayed more than one time in this location, enter total days in past 6 months.	Number of days: _____
20.	When did you first become homeless (year)?	**Year**: _____
13.	What are your current sources of income?	□Earnings from regular work □Earnings from casual work □Pension, Disability, CPP, veteran's pension □Long-term Disability (private insurer)
21.	In your lifetime, what is the total amount of time you have been homeless (months)?	**Number of Months**: _____ □Don't Know □Declined
22.	In total, what is the longest single period of homelessness (months)?	**Number of Months**: _____ □Don't Know □Declined
23.	When did your last period of homelessness end?	M _____ D_____Y_____
24.	Are you currently connected to an outreach/support worker? **If NO, SKIP to Mental Health**	□Busking (entertaining for cash) □Squeegeeing □Collecting/recycling (bottles, scrap metal etc.) □Sex Work
	Approximately how long have you been connected to your outreach worker?	**Number of Months:** _____ □Don't Know □Declined

Participant ID: _____ Date of Interview: M ____ D____Y_____

Mental Health		
1.	Have you ever been diagnosed with a mental health issue? **IF NO, SKIP to question 3**	□Yes □No □Don't Know □Declined
2.	Can you tell me what was or were the mental health diagnoses? **Do not read list. Check all that apply**	□Bipolar □Depression/Dysthymia □Developmental or □Intellectual Deficiency □Generalized Anxiety □Manic Disorder □Obsessive Compulsive □Panic Disorder □Personality Disorder □Schizophrenia □Psychotic Disorder □Phobia □Post Traumatic □Other: _____ □Don't Know □Declined
3.	Have you ever been diagnosed with a Substance Abuse/Substance Dependence Disorder?	□Yes □No □Don't Know □Declined

Mental Health and Service Use		
1.	In the past 5 years, have you been hospitalized for a mental illness at any time for longer than 6 months?	□Yes □No □Don't Know □Declined
2.	Have you ever received treatment, counseling or harm reduction services for alcohol or any drug use, not counting cigarettes?	□Yes □No □Don't Know □Declined
3.	In the past 6 months, have you been hospitalized for a mental illness?	□Yes □No □Don't Know □Declined
	About how many times were you hospitalized for a mental illness?	

Participant ID: _____ Date of Interview: M ____ D____Y_____

Rent Assistance		
1.	Are you currently (or will you be) receiving HAWS rent assistance? **IF NO, SKIP to Housing History**	□Yes □No □Don't Know □Declined
2.	When did you (will you) start receiving the HAWS rent assistance?	M _____ D_____Y_____

Housing History

Next, I'll be asking some questions about where you have been living for the **6 months (BEFORE receiving HAWS rent assistance)** [**REFER TO CALENDAR**].

Why don't we start with where you are living now and work backward from there, month by month.

Prompts: Own house, apartment, temporary stay with friends and/or relatives, homeless shelter, homeless, rooming house, boarding home, group home, single room occupancy unit, medical hospital, psychiatric hospital, substance abuse treatment facility, halfway house, nursing home, motel or hotel, jail or prison.

Current Location		
A	Location: _____ **If participant doesn't know the address, ask for major intersection/neighbourhood**	□Not Applicable □Don't Know □Declined
B	Type of Residence:	□Not Applicable □Don't Know □Declined
C	Date moved in: M _____ D_____Y_____	□Not Applicable □Don't Know □Declined
If type of residence is a shelter, treatment facility, hospital or jail, go to G		
D	Is this… □Your own place? □A place belonging to friends or family? Do you pay rent? □ Yes □No (Skip to G)	□Not Applicable □Don't Know □Declined
E	How much do YOU pay for rent: _____ **(record participants share of rent)**	□Not Applicable □Don't Know □Declined
F	Is this subsidized housing?** □Yes □No **Note: HAWS is considered subsidized housing**	□Not Applicable □Don't Know □Declined
G	Do you remember why did you move to this place?	□Not Applicable □Don't Know □Declined

Participant ID: _____ Date of Interview: M ____ D____Y_____

And what about the month before that?		
A	Location: _____ **If participant doesn't know the address, ask for major intersection/neighbourhood**	□Not Applicable □Don't Know □Declined
B	Type of Residence	□Not Applicable □Don't Know □Declined
C	Date moved in: M _____ D_____Y_____	□Not Applicable □Don't Know □Declined
D	Date moved out: M _____ D_____Y_____	□Not Applicable □Don't Know □Declined
If type of residence is a shelter, treatment facility, hospital or jail, go to G		
E	Was this… □Your own place? □A place belonging to friends or family? Did you pay rent? □ Yes □No (Skip to G)	□Not Applicable □Don't Know □Declined
F	Is this subsidized housing?** □Yes □No	□Not Applicable □Don't Know □Declined
G	Why did you move to this place?	□Not Applicable □Don't Know □Declined

*** If participant does not know whether their housing is **subsidized**, ask: "Is part or all of your rent being paid by the government, a community agency, or another organization? In other words, are you receiving support to pay your rent above and beyond any income you have."*

Participant ID: _____ Date of Interview: M ____ D____Y_____

And what about the month before that?		
A	Location: _____ **If participant doesn't know the address, ask for major intersection/neighbourhood**	□Not Applicable □Don't Know □Declined
B	Type of Residence	□Not Applicable □Don't Know □Declined
C	Date moved in: M _____ D_____Y_____	□Not Applicable □Don't Know □Declined
D	Date moved out: M _____ D_____Y_____	□Not Applicable □Don't Know □Declined
If type of residence is a shelter, treatment facility, hospital or jail, go to G		
E	Was this… □Your own place? □A place belonging to friends or family? Did you pay rent? □ Yes □No (Skip to G)	□Not Applicable □Don't Know □Declined
F	Is this subsidized housing?** □Yes □No	□Not Applicable □Don't Know □Declined
G	Why did you move to this place?	□Not Applicable □Don't Know □Declined

*** If participant does not know whether their housing is **subsidized**, ask: "Is part or all of your rent being paid by the government, a community agency, or another organization? In other words, are you receiving support to pay your rent above and beyond any income you have."*

Participant ID: _____ Date of Interview: M ____ D____Y_____

And what about the month before that?		
A	Location: _____ **If participant doesn't know the address, ask for major intersection/neighbourhood**	□Not Applicable □Don't Know □Declined
B	Type of Residence	□Not Applicable □Don't Know □Declined
C	Date moved in: M _____ D_____Y_____	□Not Applicable □Don't Know □Declined
D	Date moved out: M _____ D_____Y_____	□Not Applicable □Don't Know □Declined
If type of residence is a shelter, treatment facility, hospital or jail, go to G		
E	Was this… □Your own place? □A place belonging to friends or family? Did you pay rent? □ Yes □No (Skip to G)	□Not Applicable □Don't Know □Declined
F	Is this subsidized housing?** □Yes □No	□Not Applicable □Don't Know □Declined
G	Why did you move to this place?	□Not Applicable □Don't Know □Declined

*** If participant does not know whether their housing is **subsidized**, ask: "Is part or all of your rent being paid by the government, a community agency, or another organization? In other words, are you receiving support to pay your rent above and beyond any income you have."*

Participant ID: _____ Date of Interview: M ____ D____Y_____

And what about the month before that?		
A	Location: _____ **[If participant doesn't know the address, ask for major intersection/neighbourhood]**	□Not Applicable □Don't Know □Declined
B	Type of Residence	□Not Applicable □Don't Know □Declined
C	Date moved in: M _____ D_____Y_____	□Not Applicable □Don't Know □Declined
D	Date moved out: M _____ D_____Y_____	□Not Applicable □Don't Know □Declined
If type of residence is a shelter, treatment facility, hospital or jail, go to G		
E	Was this… □Your own place? □A place belonging to friends or family? Did you pay rent? □ Yes □No (Skip to G)	□Not Applicable □Don't Know □Declined
F	Is this subsidized housing?** □Yes □No	□Not Applicable □Don't Know □Declined
G	Why did you move to this place?	□Not Applicable □Don't Know □Declined

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B	Type of Residence	□Not Applicable □Don't Know □Declined
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E	Was this… □Your own place? □A place belonging to friends or family? Did you pay rent? □ Yes □No (Skip to G)	□Not Applicable □Don't Know □Declined
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*** If participant does not know whether their housing is **subsidized**, ask: "Is part or all of your rent being paid by the government, a community agency, or another organization? In other words, are you receiving support to pay your rent above and beyond any income you have."*

Participant ID: _____ Date of Interview: M ____ D____Y_____

Quality of Life Inventory

Now I'll read a list of things about your life overall (**BEFORE receiving HAWS rent assistance**). For each item, I'd like you to tell me how you feel (or felt) on a scale of 1 to 7. **Refer participant to Rating Scale #1**

1.	How do/did you feel about your family in general?								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
2.	How do/did you feel about how often you have contact with your family?								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
3.	How do/did you feel about the way you and your family act toward each other?								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
4.	How do/did you feel about the way things are in general between you and your family?								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
5.	How do/did you feel about how comfortable and well off you are financially?								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
6.	How do/did you feel about the amount of money you have available to spend for fun?								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
7.	How do/did you feel about the way you spend your spare time?								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
8.	How do/did you feel about the amount of time you have to do the things you want to do?								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
9.	How do/did you feel about the chance you have to enjoy pleasant or beautiful things								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
10.	How do/did you feel about the amount of fun you have?								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
11.	How do/did you feel about the amount of relaxation in your life?								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
12.	How do/did you feel about the living arrangements where you live?								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
13.	How do/did you feel about how safe you are in your neighbourhood?								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
14.	How do/did you feel about how safe you are where you live?								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
15.	How do/did you feel about the chance of finding someone to help in an emergency?								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
16.	How do/did you feel about your personal safety?								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
17.	How do/did you feel about the things you do with other people?								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
18.	How do/did you feel about the amount of time you spend with other people?								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
19.	How do/did you feel about the people you see socially?								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
20.	How do/did you feel about your life overall (as a whole)?								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined

Participant ID: _____ Date of Interview: M ____ D____Y_____

Now I'm going to ask you some questions about your relationships with others (**BEFORE receiving HAWS rent assistance**).

21.	Do you have a close confidante, that is, someone that you can share sensitive personal information with? (health, social service or other providers **do not** count as close confidantes) **IF NO, SKIP to Social Support.**	□Yes □No □Don't Know □Declined
22.	Do you see this person at least once a month? 'See' can include having contact on the phone or online as well as seeing the confidante in person	□Yes □No □Don't Know □Declined

Social Support

The next few questions are also about your relationships **BEFORE** moving into your current living situation.

Refer participant to Rating Scale #2

1.	**For this question, DO NOT include support from outreach worker:** If something went wrong, no one would help me	□Strongly Agree □Agree □Disagree □Strongly Disagree □Don't Know □Declined
1b.	**For this question, YOU MAY include support from outreach worker:** If something went wrong, no one would help me	□Strongly Agree □Agree □Disagree □Strongly Disagree □Don't Know □Declined
2.	I have family and friends who help me feel safe, secure and happy	□Strongly Agree □Agree □Disagree □Strongly Disagree □Don't Know □Declined
3.	**For this question, DO NOT include support from outreach worker:** There is someone I trust whom I could turn to for advice if I were having problems	□Strongly Agree □Agree □Disagree □Strongly Disagree □Don't Know □Declined
3b.	**For this question, YOU MAY include support from outreach worker:** There is someone I trust whom I could turn to for advice if I were having problems	□Strongly Agree □Agree □Disagree □Strongly Disagree □Don't Know □Declined

Participant ID: _____ Date of Interview: M ____ D____Y_____

4.	**For this question, <u>DO NOT</u> include support from outreach worker:** There is no one I feel comfortable talking about problems with	□Strongly Agree □Agree □Disagree □Strongly Disagree □Don't Know □Declined
4b.	**For this question, <u>YOU MAY</u> include support from outreach worker:** There is no one I feel comfortable talking about problems with	□Strongly Agree □Agree □Disagree □Strongly Disagree □Don't Know □Declined
5.	**For this question, <u>DO NOT</u> include support from outreach worker:** I lack a feeling of intimacy with another person	□Strongly Agree □Agree □Disagree □Strongly Disagree □Don't Know □Declined
5b.	**For this question, <u>YOU MAY</u> include support from outreach worker:** I lack a feeling of intimacy with another person	□Strongly Agree □Agree □Disagree □Strongly Disagree □Don't Know □Declined

Participant ID: _____ Date of Interview: M ____ D____Y_____

Working Alliance Inventory

Now I will read a list of sentences that describe some of the different ways a person might think or feel about their outreach/support worker.

For each item, I'd like you to tell me how much you agree with the statement on a scale of 1 to 7.

Refer participant to Rating Scale #3

1.	My outreach worker and I agree about the things I will need to do to help improve my situation								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
2.	The support I receive from my outreach worker gives me new ways of looking at my situation								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
3.	I believe my outreach worker likes me								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
4.	My outreach worker does not understand the types of support services that I need								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
5.	I am confident in my outreach worker's ability to support me								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
6.	My outreach worker and I are working towards mutually agreed upon goals								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
7.	I feel that my outreach worker appreciates me								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
8.	We agree on what is important for me to work on								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
9.	My outreach worker and I trust one another								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
10.	My outreach worker and I have different ideas about what goals I should set for myself								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
11.	We have established a good understanding of the kind of changes that would be good for me								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined
12.	I believe we are taking the correct approach to working towards my goals								
	1	2	3	4	5	6	7	□ Don't Know	□ Declined

Participant ID: _____ Date of Interview: M ____ D____Y_____

Multnomah Community Ability

The following questions ask about how things have gone in your life in the past month **BEFORE receiving HAWS rent assistance**.

Refer participant to Rating Scale #4

Health		
This section is about how you have been managing in your day-to-day life. **Over the past 30 days BEFORE moving into your current living situation:**		
1.	How much have physical health problems kept you from doing things?	□Very much □A lot □Somewhat □Slightly □Not at all □Don't Know □Declined
2.	How much trouble have you had with your thoughts? For example, seeing or hearing things that other people don't or difficulty in organizing your thinking	□Very much trouble □A lot of trouble □Some trouble □Slight trouble □No trouble □Don't Know □Declined
3.	How much trouble have you had with your moods? For example, extreme mood swings, being depressed, or getting overly excited	□Very much trouble □A lot of trouble □Some trouble □Slight trouble □No trouble □Don't Know □Declined
4.	How much trouble have you had handling stress?	□Very much trouble □A lot of trouble □Some trouble □Slight trouble □No trouble □Don't Know □Declined

Participant ID: _____ Date of Interview: M ____ D____Y_____

Adaptation		
This section is about issues related to your physical and mental health that might have made life harder for you. **Over the past 30 days <u>BEFORE receiving HAWS</u>**:		
5.	How successfully have you managed your money?	□Almost always or always managed money successfully □Often managed money successfully □Sometimes managed money successfully □Seldom managed money successfully □Never or almost never managed money successfully □Don't Know □Declined
6.	How well have you managed day-to-day tasks on your own? For example, keeping clean, eating regularly,, shopping, or housecleaning	□Almost always or always on my own □Often on my own □Sometimes on my own □Seldom on my own □Never or almost never on my own □Don't Know □Declined

Participant ID: _____ Date of Interview: M ____ D____Y_____

Social Skills		
This section is about how you interact with other people. **Over the past 30 days BEFORE receiving HAWS.**		
7.	How frequently have you gotten together with other people?	□Very often □Often □Sometimes □Seldom □Never or almost never □Don't Know □Declined
8.	How well have you gotten along with other people?	□Very well □Well □Okay □Badly □Very Badly □Don't Know □Declined
9.	How large a group of people do you currently know? Including family, friends, acquaintances, co-workers, and professionals	□Very large group □Large group □Medium-sized group □Small group □Very small group □Don't Know □Declined
10.	How often have you been involved in activities that were satisfying to you?	□Very often □Often □Sometimes □Seldom □Never or almost never □Don't Know □Declined

Participant ID: _____ Date of Interview: M ____ D____Y_____

Behaviour		
This section is about behaviors that might have made it difficult for you to manage in the community **over the past 30 days <u>BEFORE receiving HAWS</u>.**		
11.	If you have been diagnosed with a mental illness, are you required to take medications? If so, how often have you taken your mental health medications just as they were prescribed? **If not applicable, circle NA**	□Almost always or always □Often □Sometimes □Seldom □Never or almost never □NA □Don't Know □Declined
12.	Have you been in treatment? If so, how often have you actively participated in your treatment? For example, following through on treatment plans, keeping appointments? **If not applicable, circle NA**	□Almost always or always □Often □Sometimes □Seldom □Never or almost never □NA □Don't Know □Declined
13.	How often have you abused drugs and/or alcohol? "Abuse" means using to the point it causes problems.	□Almost always or always □Often □Sometimes □Seldom □Never or almost never □NA □Don't Know □Declined
14.	How often have you lost control of your behavior? For example, losing your temper, threatening or attacking others, attempting suicide, behaving recklessly, or destroying property	□Very often □Often □Sometimes □Seldom □Almost never or never □Don't Know □Declined

Participant ID: _____ Date of Interview: M ____ D____Y_____

Food Security		**Refer participant to Rating Scale #5**
Now I'm going to read you several statements that people have made about their food situation. For these statements, please tell me whether the statement was *often true, sometimes true, or never true* for you in **the last 30 days BEFORE receiving HAWS rent assistance.**		
1.	I worried whether my food would run out before I could get more.	□Often true □Sometimes true □Never true □Don't Know □Declined
2.	The food that I got just didn't last, and I couldn't get more.	□Often true □Sometimes true □Never true □Don't Know □Declined
3.	I couldn't eat balanced meals. By balanced we mean eating different types of foods to get a wide range of nutrients E.g. fibre, vitamins, minerals	□Often true □Sometimes true □Never true □Don't Know □Declined
4.	Did you ever cut the size of your meals or skip meals because you couldn't get enough food?	□Yes □No □Don't Know □Declined
	How many days did this happen?	
5.	Did you ever eat less than you felt you should because you couldn't get enough food?	□Yes □No □Don't Know □Declined
6.	Were you ever hungry but didn't eat because you couldn't get enough food?	□Yes □No □Don't Know □Declined
7.	Did you lose weight because you couldn't get enough food?	□Yes □No □Don't Know □Declined
8.	Did you ever not eat for a whole day because you couldn't get enough food?	□Yes □No □Don't Know □Declined
	How many days did this happen?	
9.	Would you say that the food you get is nutritious? By nutritious we mean a variety of whole foods incl. fruits and vegetables	□Yes □No □Don't Know □Declined

Participant ID: _____ Date of Interview: M ____ D____Y_____

Justice Services Use

Now I would like to go over some of the justice services you may have received in the **6 months BEFORE moving into your current living situation.**

This information is needed in the study to see if housing relates to things like police contacts.
Your answers are confidential and for the research only.

Once again I'd like to use a calendar to help us figure out what services you've received during this time period [**REER TO CALENDAR**].

1.	In the past 6 months, have you had contacts with the police that did NOT result in detention, arrest, charge, or conviction? By contacts we mean any time you talked directly with a police officer about any concern or any time a police officer talked directly with you. **IF they say NO, SKIP to question 2**	□Yes □No □Don't Know □Declined
	How many times?	
2.	In the past 6 months, have you been detained by the police or taken anywhere by the police (other than a police cell)? For example, have the police taken you to a hospital, shelter, or a residence? **IF they say NO, SKIP to question 3**	□Yes □No □Don't Know □Declined
	How many times?	
3.	In the past 6 months, have you been held in a police cell for 24 hours of less? **IF they say NO, SKIP to Arrests**	□Yes □No □Don't Know □Declined
	How many times?	

Arrests		
4.	In the past 6 months, have you been arrested? **IF they say NO, SKIP to Health an Social Service Use**	□Yes □No □Don't Know □Declined
	How many times?	
	Did this arrest result in a formal charge?	□Yes □No □Don't Know □Declined

Participant ID: _____ Date of Interview: M ____ D____Y_____

Health and Social Service Use

Now I would like to go over some of the healthcare and social services you may have received.

1.	In the **past month BEFORE moving into your current living situation**, have you seen a health or social services provider? By a **health provider** we mean someone you have seen for a health concern (E.g. doctor, nurse, psychiatrist). By a **social services provider** we mean someone you have seen to get help with things like housing and finances (E.g. housing worker, social worker, and including justice workers such as probation officers). **IF they say NO, SKIP to question 2**	□Yes □No □Don't Know □Declined
	Who have you seen this past month?	
	How many times?	
	What kind of service did you get from this person?	□Medication review □Combined medication and therapy □Individual therapy □Diagnostic/assessment □General physical exam □Specific health concern □Other □Don't Know □Declined
2.	At anytime in the past six months, have you called or been visited by a crisis team (including a crisis line, 911 or other health line)? **IF they say NO, SKIP to question 3**	□Yes □No □Don't Know □Declined
	How many times did you call?	
3.	In the past 6 months, have you been to a hospital emergency room? **If they say NO, skip to question 4**	□Yes □No □Don't Know □Declined
	About how many emergency room visits did you have in total?	
	What was the reason for that ER visit? **"Other" may include: to get a prescription; to get warm, food or rest; or forced against will, etc.**	□Psychiatric □Medical □Other □Don't Know □Declined

Participant ID: _____ Date of Interview: M ____ D____Y_____

4.	At any time in the past 6 months, have you been taken by ambulance to a hospital? **If they say NO, skip to question 5**	□Yes □No □Don't Know □Declined
	Approximately how many ambulance trips did you have?	
6.	And, in the past 6 months, have you been to any drop-in centres, community meal centres, or meal programs **Do not count places that you stayed overnight, but do include shelters if you did NOT stay overnight** **If they say NO, skip to question 6**	□Yes □No □Don't Know □Declined
	How many times did you go?	
7.	Any time in the past 6 months, did you go to a food bank to get food? **IF they say NO, SKIP to end of interview**	□Yes □No □Don't Know □Declined
	How many times did you go?	

We are now finished the interview. I thank you so much for being willing to go through all of this with me today. Do you mind if I take a few minutes to check through and make sure I haven't missed anything?

I would like to take some time to check in with you and see how you are doing, now that the interview is complete. Do you have any questions or concerns that you would like to address with me before we part?

Refer participant to resource card and ask if they would like to connect with their STEP Home/outreach worker.

Appendix G. Follow-Up Interview

Participant ID: _____ Date of Interview: M____ D____ Y_____

Housing History

Now I'll start with the interview questions. I'll begin by asking some questions about where you have been living for past the **6 months** [**REFER TO CALENDAR**].

Why don't we start with where you are living now and work backward from there, month by month.

Prompts: Own house, apartment, temporary stay with friends and/or relatives, homeless shelter, homeless, rooming house, boarding home, group home, single room occupancy unit, medical hospital, psychiatric hospital, substance abuse treatment facility, halfway house, nursing home, motel or hotel, jail or prison.

Current Location		
A	Location: _____ **If participant doesn't know the address, ask for major intersection/neighbourhood**	☐Not Applicable ☐Don't Know ☐Declined
B	Type of Residence:	☐Not Applicable ☐Don't Know ☐Declined
C	Date moved in: M_____D_____Y_____	☐Not Applicable ☐Don't Know ☐Declined
If type of residence is a shelter, treatment facility, hospital or jail, go to G		
D	Is this… ☐Your own place? ☐A place belonging to friends or family? Do you pay rent? ☐ Yes ☐No (Skip to G)	☐Not Applicable ☐Don't Know ☐Declined
E	How much do YOU pay for rent: _____ **participants share of rent**	☐Not Applicable ☐Don't Know ☐Declined
F	Is this subsidized housing?** ☐Yes ☐No	☐Not Applicable ☐Don't Know ☐Declined
G	Do you remember why did you move to this place?	☐Not Applicable ☐Don't Know ☐Declined

*** If participant does not know whether their housing is **subsidized**, ask: "Is part or all of your rent being paid by the government, a community agency, or another organization? In other words, are you receiving support to pay your rent above and beyond any income you have."*

Participant ID: _____ Date of Interview: M____ D____ Y_____

And what about the month before that?		
A	Location: _____ **[If participant doesn't know the address, ask for major intersection or neighbourhood]**	☐Not Applicable ☐Don't Know ☐Declined
B	Type of Residence	☐Not Applicable ☐Don't Know ☐Declined
C	Date moved in: M_____ D_____ Y_____	☐Not Applicable ☐Don't Know ☐Declined
D	Date moved out: M_____ D_____ Y_____	☐Not Applicable ☐Don't Know ☐Declined
If type of residence is a shelter, treatment facility, hospital or jail, go to G		
E	Is this… ☐Your own place? ☐A place belonging to friends or family? Do you pay rent? ☐ Yes ☐No (Skip to G)	☐Not Applicable ☐Don't Know ☐Declined
F	Is this subsidized housing?** ☐Yes ☐No	☐Not Applicable ☐Don't Know ☐Declined
G	Why did you move to this place?	☐Not Applicable ☐Don't Know ☐Declined

*** If participant does not know whether their housing is **subsidized**, ask: "Is part or all of your rent being paid by the government, a community agency, or another organization? In other words, are you receiving support to pay your rent above and beyond any income you have."*

Participant ID: _____ Date of Interview: M____ D____ Y_____

And what about the month before that?		
A	Location: _____ **[If participant doesn't know the address, ask for major intersection or neighbourhood]**	☐Not Applicable ☐Don't Know ☐Declined
B	Type of Residence	☐Not Applicable ☐Don't Know ☐Declined
C	Date moved in: M_____ D_____ Y_____	☐Not Applicable ☐Don't Know ☐Declined
D	Date moved out: M_____ D_____ Y_____	☐Not Applicable ☐Don't Know ☐Declined
If type of residence is a shelter, treatment facility, hospital or jail, go to G		
E	Is this… ☐Your own place? ☐A place belonging to friends or family? Do you pay rent? ☐ Yes ☐No (Skip to G)	☐Not Applicable ☐Don't Know ☐Declined
F	Is this subsidized housing?** ☐Yes ☐No	☐Not Applicable ☐Don't Know ☐Declined
G	Why did you move to this place?	☐Not Applicable ☐Don't Know ☐Declined

*** If participant does not know whether their housing is **subsidized**, ask: "Is part or all of your rent being paid by the government, a community agency, or another organization? In other words, are you receiving support to pay your rent above and beyond any income you have."*

Participant ID: _____ Date of Interview: M____ D____ Y_____

And what about the month before that?		
A	Location: _____ **[If participant doesn't know the address, ask for major intersection or neighbourhood]**	☐Not Applicable ☐Don't Know ☐Declined
B	Type of Residence	☐Not Applicable ☐Don't Know ☐Declined
C	Date moved in: M_____ D_____ Y_____	☐Not Applicable ☐Don't Know ☐Declined
D	Date moved out: M_____ D_____ Y_____	☐Not Applicable ☐Don't Know ☐Declined
If type of residence is a shelter, treatment facility, hospital or jail, go to G		
E	Is this… ☐Your own place? ☐A place belonging to friends or family? Do you pay rent? ☐ Yes ☐No (Skip to G)	☐Not Applicable ☐Don't Know ☐Declined
F	Is this subsidized housing?** ☐Yes ☐No	☐Not Applicable ☐Don't Know ☐Declined
G	Why did you move to this place?	☐Not Applicable ☐Don't Know ☐Declined

*** If participant does not know whether their housing is **subsidized**, ask: "Is part or all of your rent being paid by the government, a community agency, or another organization? In other words, are you receiving support to pay your rent above and beyond any income you have."*

Participant ID: _____ Date of Interview: M____ D____ Y_____

And what about the month before that?		
A	Location: _____ **[If participant doesn't know the address, ask for major intersection or neighbourhood]**	☐Not Applicable ☐Don't Know ☐Declined
B	Type of Residence	☐Not Applicable ☐Don't Know ☐Declined
C	Date moved in: M_____ D_____ Y_____	☐Not Applicable ☐Don't Know ☐Declined
D	Date moved out: M_____ D_____ Y_____	☐Not Applicable ☐Don't Know ☐Declined
If type of residence is a shelter, treatment facility, hospital or jail, go to G		
E	Is this… ☐Your own place? ☐A place belonging to friends or family? Do you pay rent? ☐ Yes ☐No (Skip to G)	☐Not Applicable ☐Don't Know ☐Declined
F	Is this subsidized housing?** ☐Yes ☐No	☐Not Applicable ☐Don't Know ☐Declined
G	Why did you move to this place?	☐Not Applicable ☐Don't Know ☐Declined

*** If participant does not know whether their housing is **subsidized**, ask: "Is part or all of your rent being paid by the government, a community agency, or another organization? In other words, are you receiving support to pay your rent above and beyond any income you have."*

Participant ID: _____ Date of Interview: M____ D____ Y_____

Quality of Life Inventory

Now I'll read a list of things about your life overall.

For each item, I'd like you to tell me how you feel on a scale of 1 to 7. **Refer participant to Rating Scale #1**

1.	How do you feel about your family in general?								
	1	2	3	4	5	6	7	☐ Don't Know	☐ Declined
2.	How do you feel about how often you have contact with your family?								
	1	2	3	4	5	6	7	☐ Don't Know	☐ Declined
3.	How do you feel about the way you and your family act toward each other?								
	1	2	3	4	5	6	7	☐ Don't Know	☐ Declined
4.	How do you feel about the way things are in general between you and your family?								
	1	2	3	4	5	6	7	☐ Don't Know	☐ Declined
5.	How do you feel about how comfortable and well off you are financially?								
	1	2	3	4	5	6	7	☐ Don't Know	☐ Declined
6.	How do you feel about the amount of money you have available to spend for fun?								
	1	2	3	4	5	6	7	☐ Don't Know	☐ Declined
7.	How do you feel about the way you spend your spare time?								
	1	2	3	4	5	6	7	☐ Don't Know	☐ Declined
8.	How do you feel about the amount of time you have to do the things you want to do?								
	1	2	3	4	5	6	7	☐ Don't Know	☐ Declined
9.	How do you feel about the chance you have to enjoy pleasant or beautiful things								
	1	2	3	4	5	6	7	☐ Don't Know	☐ Declined
10.	How do you feel about the amount of fun you have?								
	1	2	3	4	5	6	7	☐ Don't Know	☐ Declined
11.	How do you feel about the amount of relaxation in your life?								
	1	2	3	4	5	6	7	☐ Don't Know	☐ Declined
12.	How do you feel about the living arrangements where you live?								
	1	2	3	4	5	6	7	☐ Don't Know	☐ Declined
13.	How do you feel about how safe you are in your neighbourhood?								
	1	2	3	4	5	6	7	☐ Don't Know	☐ Declined
14.	How do you feel about how safe you are where you live?								
	1	2	3	4	5	6	7	☐ Don't Know	☐ Declined
15.	How do you feel about the chance of finding someone to help in an emergency?								
	1	2	3	4	5	6	7	☐ Don't Know	☐ Declined
16.	How do you feel about your personal safety?								
	1	2	3	4	5	6	7	☐ Don't Know	☐ Declined
17.	How do you feel about the things you do with other people?								
	1	2	3	4	5	6	7	☐ Don't Know	☐ Declined
18.	How do you feel about the amount of time you spend with other people?								
	1	2	3	4	5	6	7	☐ Don't Know	☐ Declined
19.	How do you feel about the people you see socially?								
	1	2	3	4	5	6	7	☐ Don't Know	☐ Declined
20.	How do you feel about your life overall (as a whole)?								
	1	2	3	4	5	6	7	☐ Don't Know	☐ Declined

Participant ID: _____ Date of Interview: M____ D____ Y_____

Now I'm going to ask you some questions about your relationships with others.

21.	Do you have a close confidante, that is, someone that you can share sensitive personal information with? (health, social service or other providers **do not** count as close confidantes) **IF NO, SKIP to Social Support.**	☐Yes ☐No ☐Don't Know ☐Declined
22.	Do you see this person at least once a month? 'See' can include having contact on the phone or online as well as seeing the confidante in person	☐Yes ☐No ☐Don't Know ☐Declined

Social Support

The next few questions are also about your relationships over the **past 6 months**.
Refer participant to Rating Scale #2

1.	**For this question, DO NOT include support from outreach worker:** If something went wrong, no one would help me	☐Strongly Agree ☐Agree ☐Disagree ☐Strongly Disagree ☐Don't Know ☐Declined
1b.	**For this question, YOU MAY include support from outreach worker:** If something went wrong, no one would help me	☐Strongly Agree ☐Agree ☐Disagree ☐Strongly Disagree ☐Don't Know ☐Declined
2.	I have family and friends who help me feel safe, secure and happy	☐Strongly Agree ☐Agree ☐Disagree ☐Strongly Disagree ☐Don't Know ☐Declined
3.	**For this question, DO NOT include support from outreach worker:** There is someone I trust whom I could turn to for advice if I were having problems	☐Strongly Agree ☐Agree ☐Disagree ☐Strongly Disagree ☐Don't Know ☐Declined
3b.	**For this question, YOU MAY include support from outreach worker:** There is someone I trust whom I could turn to for advice if I were having problems	☐Strongly Agree ☐Agree ☐Disagree ☐Strongly Disagree ☐Don't Know ☐Declined

Participant ID: _____ Date of Interview: M____ D____ Y_____

4.	**For this question, DO NOT include support from outreach worker:** There is no one I feel comfortable talking about problems with	☐Strongly Agree ☐Agree ☐Disagree ☐Strongly Disagree ☐Don't Know ☐Declined
4b.	**For this question, YOU MAY include support from outreach worker:** There is no one I feel comfortable talking about problems with	☐Strongly Agree ☐Agree ☐Disagree ☐Strongly Disagree ☐Don't Know ☐Declined
5.	**For this question, DO NOT include support from outreach worker:** I lack a feeling of intimacy with another person	☐Strongly Agree ☐Agree ☐Disagree ☐Strongly Disagree ☐Don't Know ☐Declined
5b.	**For this question, YOU MAY include support from outreach worker:** I lack a feeling of intimacy with another person	☐Strongly Agree ☐Agree ☐Disagree ☐Strongly Disagree ☐Don't Know ☐Declined

Participant ID: _____ Date of Interview: M____ D____ Y_____

Multnomah Community Ability

The following questions ask about how things have gone in your life over **the past month.**

Refer participant to Rating Scale #3

Health		
This section is about issues related to your physical and mental health that might have made life harder for you. **Over the past 30 days:**		
1.	How much have physical health problems kept you from doing things?	☐Very much ☐A lot ☐Somewhat ☐Slightly ☐Not at all ☐Don't Know ☐Declined
2.	How much trouble have you had with your thoughts? For example, seeing or hearing things that other people don't or difficulty in organizing your thinking	☐Very much trouble ☐A lot of trouble ☐Some trouble ☐Slight trouble ☐No trouble ☐Don't Know ☐Declined
3.	How much trouble have you had with your moods? For example, extreme mood swings, being depressed, or getting overly excited	☐Very much trouble ☐A lot of trouble ☐Some trouble ☐Slight trouble ☐No trouble ☐Don't Know ☐Declined
4.	How much trouble have you had handling stress?	☐Very much trouble ☐A lot of trouble ☐Some trouble ☐Slight trouble ☐No trouble ☐Don't Know ☐Declined

Participant ID: _____ Date of Interview: M____ D____ Y_____

Adaptation		
This section is about how you have been managing in your day-to-day life. **Over the past 30 days:**		
5.	How successfully have you managed your money?	☐ Almost always or always managed money successfully ☐ Often managed money successfully ☐ Sometimes managed money successfully ☐ Seldom managed money successfully ☐ Never or almost never managed money successfully ☐ Don't Know ☐ Declined
6.	How well have you managed day-to-day tasks on your own? For example, keeping clean, eating regularly, shopping, or housecleaning	☐ Almost always or always on my own ☐ Often on my own ☐ Sometimes on my own ☐ Seldom on my own ☐ Never or almost never on my own ☐ Don't Know ☐ Declined

Participant ID: _____ Date of Interview: M____ D____ Y_____

Social Skills		
This section is about how you interact with other people. **Over the past 30 days:**		
7.	How frequently have you gotten together with other people?	☐Very often ☐Often ☐Sometimes ☐Seldom ☐Never or almost never ☐Don't Know ☐Declined
8.	How well have you gotten along with other people?	☐Very well ☐Well ☐Okay ☐Badly ☐Very Badly ☐Don't Know ☐Declined
9.	How large a group of people do you currently know? Including family, friends, acquaintances, co-workers, and professionals	☐Very large group ☐Large group ☐Medium-sized group ☐Small group ☐Very small group ☐Don't Know ☐Declined
10.	How often have you been involved in activities that were satisfying to you?	☐Very often ☐Often ☐Sometimes ☐Seldom ☐Never or almost never ☐Don't Know ☐Declined

Participant ID: _____ Date of Interview: M____ D____ Y_____

Behaviour		
This section is about behaviors that might have made it difficult for you to manage in the community. **Over the past 30 days:**		
11.	If you have been diagnosed with a mental illness, are you required to take medications? If so, how often have you taken your mental health medications just as they were prescribed? **If not applicable, circle NA**	☐ Almost always or always ☐ Often ☐ Sometimes ☐ Seldom ☐ Never or almost never ☐ NA ☐ Don't Know ☐ Declined
12.	Have you been in treatment? If so, how often have you actively participated in your treatment? For example, following through on treatment plans, keeping appointments? **If not applicable, circle NA**	☐ Almost always or always ☐ Often ☐ Sometimes ☐ Seldom ☐ Never or almost never ☐ NA ☐ Don't Know ☐ Declined
13.	How often have you abused drugs and/or alcohol? "Abuse" means using to the point that you believe it causes problems.	☐ Almost always or always ☐ Often ☐ Sometimes ☐ Seldom ☐ Never or almost never ☐ NA ☐ Don't Know ☐ Declined
14.	How often have you lost control of your behavior? For example, losing your temper, threatening or attacking others, attempting suicide, behaving recklessly, or destroying property	☐ Very often ☐ Often ☐ Sometimes ☐ Seldom ☐ Almost never or never ☐ Don't Know ☐ Declined

Perceived Housing Quality	
1.	If the participant is currently housed enter **YES** and continue. If they are on the street, in a shelter or in an institution enter **NO** and **SKIP to Food Security.** ☐ Yes ☐ No (Skip to Food Security)

Participant ID: _____ Date of Interview: M____ D____ Y_____

Housing Program Choice

The next few questions are about the choice and quality of where you currently live.

Refer participant to Rating Scale #4

How do you feel about:

2.	How long you will be able to live in your place?	☐Very satisfied ☐Satisfied ☐Neither ☐Dissatisfied ☐Very dissatisfied ☐Don't Know ☐Declined
3.	How affordable your place is?	☐Very satisfied ☐Satisfied ☐Neither ☐Dissatisfied ☐Very dissatisfied ☐Don't Know ☐Declined
4.	How easy it is to contact your STEP Home or outreach worker whenever you need to?	☐Very satisfied ☐Satisfied ☐Neither ☐Dissatisfied ☐Very dissatisfied ☐Don't Know ☐Declined
5.	How much choice do you have about whether or not to see your STEP Home or outreach worker?	☐Very satisfied ☐Satisfied ☐Neither ☐Dissatisfied ☐Very dissatisfied ☐Don't Know ☐Declined
6	The choice you have about the types of housing and support services you receive.	☐Very satisfied ☐Satisfied ☐Neither ☐Dissatisfied ☐Very dissatisfied ☐Don't Know ☐Declined

Participant ID: _____ Date of Interview: M____ D____ Y_____

Housing Quality

Refer participant to Rating Scale #5

7.	How would you rate your current home for safety?	☐Very good ☐Somewhat good ☐Neither good nor bad ☐Somewhat bad ☐Very bad ☐Don't Know ☐Declined
8.	How about spaciousness (that is, feeling like you have enough space to live comfortably)?	☐Very good ☐Somewhat good ☐Neither good nor bad ☐Somewhat bad ☐Very bad ☐Don't Know ☐Declined
9.	How about privacy? By privacy, we mean feeling like you will not be disturbed by other people.	☐Very good ☐Somewhat good ☐Neither good nor bad ☐Somewhat bad ☐Very bad ☐Don't Know ☐Declined
10.	How about friendliness? That is, feeling like you are in a pleasant and welcoming place.	☐Very good ☐Somewhat good ☐Neither good nor bad ☐Somewhat bad ☐Very bad ☐Don't Know ☐Declined
11.	And how would you rate your current home for overall quality?	☐Very good ☐Somewhat good ☐Neither good nor bad ☐Somewhat bad ☐Very bad ☐Don't Know ☐Declined

Participant ID: _____ Date of Interview: M____ D____ Y_____

Food Security

Now I'm going to read you several statements that people have made about their food situation.
For these statements, please tell me whether the statement was *often true, sometimes true, or never true* for you in **the last 30 days.** **Refer participant to Rating Scale #6**

1.	I worried whether my food would run out before I could get more.	☐Often true ☐Sometimes true ☐Never true ☐Don't Know ☐Declined
2.	The food that I got just didn't last, and I couldn't get more.	☐Often true ☐Sometimes true ☐Never true ☐Don't Know ☐Declined
3.	I couldn't eat balanced meals. By balanced we mean eating different types of foods to get a wide range of nutrients E.g. fibre, vitamins, minerals	☐Often true ☐Sometimes true ☐Never true ☐Don't Know ☐Declined
4.	Did you ever cut the size of your meals or skip meals because you couldn't get enough food?	☐Yes ☐No ☐Don't Know ☐Declined
	How many days did this happen?	
5.	Did you ever eat less than you felt you should because you couldn't get enough food?	☐Yes ☐No ☐Don't Know ☐Declined
6.	Were you ever hungry but didn't eat because you couldn't get enough food?	☐Yes ☐No ☐Don't Know ☐Declined
7.	Did you lose weight because you couldn't get enough food?	☐Yes ☐No ☐Don't Know ☐Declined
8.	Did you ever not eat for a whole day because you couldn't get enough food?	☐Yes ☐No ☐Don't Know ☐Declined
	How many days did this happen?	
9.	Would you say that the food you get is nutritious? By nutritious we mean a variety of whole foods incl. fruits and vegetables	☐Yes ☐No ☐Don't Know ☐Declined

Participant ID: _____ Date of Interview: M____ D____ Y____

Justice Services Use

Now I would like to go over some of the justice services you may have received in the **past 6 months.**

This information is needed in the study to see if housing relates to things like police contacts.
Your answers are confidential and for the research only.

Once again I'd like to use a calendar to help us figure out what services you've received during this time period [**REFER TO CALENDAR**].

1.	In the past 6 months, have you had contacts with the police that did NOT result in detention, arrest, charge, or conviction? By contacts we mean any time you talked directly with a police officer about any concern or any time a police officer talked directly with you. **IF they say NO, SKIP to question 2**	☐Yes ☐No ☐Don't Know ☐Declined
	How many times?	
2.	In the past 6 months, have you been detained by the police or taken anywhere by the police (other than a police cell)? For example, have the police taken you to a hospital, shelter, or a residence? **IF they say NO, SKIP to question 3**	☐Yes ☐No ☐Don't Know ☐Declined
	How many times?	
3.	In the past 6 months, have you been held in a police cell for 24 hours of less? **IF they say NO, SKIP to Arrests**	☐Yes ☐No ☐Don't Know ☐Declined
	How many times?	

Arrests		
4.	In the past 6 months, have you been arrested? **IF they say NO, SKIP to Health and Social Service Use**	☐Yes ☐No ☐Don't Know ☐Declined
	How many times?	
	Did this arrest result in a formal charge?	☐Yes ☐No ☐Don't Know ☐Declined

Participant ID: _____ Date of Interview: M____ D____ Y_____

Health and Social Service Use

Now I would like to go over some of the healthcare and social services you may have received.

1.	In **the past month**, have you seen a health or social services provider? By a **health provider** we mean someone you have seen for a health concern (E.g. doctor, nurse, psychiatrist). By a **social services provider** we mean someone you have seen to get help with things like housing and finances (E.g. housing worker, social worker, and including justice workers such as probation officers). **IF they say NO, SKIP to question 2**	☐Yes ☐No ☐Don't Know ☐Declined
	Who have you seen this past month?	
	How many times?	
	What kind of service did you get from this person?	☐Medication review ☐Combined medication and therapy ☐Individual therapy ☐Diagnostic/assessment ☐General physical exam ☐Specific health concern ☐Other _____ ☐Don't Know ☐Declined
2.	At anytime in the past six months, have you called or been visited by a crisis team (including a crisis line, 911 or other health line)? **IF they say NO, SKIP to question 3**	☐Yes ☐No ☐Don't Know ☐Declined
	How many times did you call?	
3.	In the past 6 months, have you been to a hospital emergency room? **If they say NO, skip to question 4**	☐Yes ☐No ☐Don't Know ☐Declined
	About how many emergency room visits did you have in total?	
	What was the reason for that ER visit? **"Other" may include: to get a prescription; to get warm, food or rest; or forced against will, etc.**	☐Psychiatric ☐Medical ☐Other ☐Don't Know ☐Declined

Participant ID: _____ Date of Interview: M____ D____ Y_____

4.	At any time in the **past 6 months**, have you been taken by ambulance to a hospital? **If they say NO, skip to question 5**	☐Yes ☐No ☐Don't Know ☐Declined
	Approximately how many ambulance trips did you have?	
5.	In the **past 6 months**, have you been hospitalized for a mental illness?	☐Yes ☐No ☐Don't Know ☐Declined
	About how many times were you hospitalized for a mental illness?	
6.	And, in the **past 6 months**, have you been to any drop-in centres, community meal centres, or meal programs **Do not count places that you stayed overnight, but do include shelters if you did NOT stay overnight** **If they say NO, skip to question 6**	☐Yes ☐No ☐Don't Know ☐Declined
	How many times did you go?	
7.	Any time in the past 6 months, did you go to a food bank to get food? **IF they say NO, SKIP to end of interview**	☐Yes ☐No ☐Don't Know ☐Declined
	How many times did you go?	

We are now finished the interview. I thank you so much for being willing to go through all of this with me today. Do you mind if I take a few minutes to check through and make sure I haven't missed anything?

I would like to take some time to check in with you and see how you are doing, now that the interview is complete. Refer participant to resource card and ask if they would like to connect with their STEP Home or outreach worker.

Appendix H. Qualitative Interview

INTERVIEW GUIDE FOR FOLLOW-UP QUALITATIVE INTERVIEW WATERLOO HOUSING FIRST PILOT STUDY

Introduction

[Complete informed consent]

This part of the interview is an opportunity for you to tell the story about your experiences over the past 6 months. We're interested in learning about your life experiences, personal changes, housing, and supports. You've been asked about some of these issues in the previous part of the interview. This part of the interview is an opportunity for you to share those experiences and to talk about your life using your own words. Take the time you need. For most people this part of the interview takes about 20-30 minutes, but how much time we take to do the interview is up to you. We can take a break if you wish.

Just as a reminder, please be aware that your participation in the study is completely voluntary. You can decide not to participate, to withdraw your participation at any time, and to skip any questions that you do not wish to answer. Also, your decision to participate or not participate will not affect the services or support your receive. You may find some of these questions sensitive or disturbing. We will only proceed with the interview today if you feel comfortable doing so. We are interested in hearing about your life. Please keep in mind though that this is a research interview and not a clinical or therapeutic interview. If you do have concerns and questions about resources or support, we will be able to provide you with information after the interview. We will hold everything that you say in confidence. Please note that your name will not be associated in any way with your responses.

Do you have any questions before we get started? I'm going to start the recorder now – is that still okay with you?

LIFE STORY FOR THE PAST 6 MONTHS

I would like to hear about your experiences over the past 6 months. And in particular, how things may or may not have changed since the last time we met. I will ask you some questions about some of your experiences.
!

Theme 1: Housing & Rent Assistance

Are you currently housed?

☐ **Yes - For participants who have indicated that they are currently housed.**

1. Tell me about your current housing.
    a. What do you like about it?
    b. What don't you like about it?
    c. What was your biggest struggle with your new housing?
    d. What could have helped to make that easier?
    e. What was your biggest success with your new housing?
    f. What helped make that possible?

2. What difference has housing made in your life?
    a. How has it impacted your quality of life?

☐ **No - For participants who have indicated that they are not currently housed.**

1. Would you like to have your own place? If so, what are your current challenges with securing housing?

Are you currently receiving rent assistance?
Rent assistance includes any top-ups you may be receiving to help pay for rent
(e.g. HAWS, co-op housing, THAWS)

☐ **Yes - For participants who have indicated that they <u>are</u> receiving rent assistance:**

1. What difference has rent assistance made in your life and in the types of housing that you were able to find?
    a. How has it had an impact on your health and well-being?

☐ **No - For participants who have indicated that they <u>are not</u> receiving rent assistance:**
If participant is <u>not currently housed</u>, SKIP TO QUESTION 3.

1. What type of housing do you currently live in?
(e.g., shared apartment, bachelor apt, rooming house, staying with a friend)

2. How would you describe that housing?

3. What difference would rent assistance make in your life?
    a. Impact on your health and well-being?

Theme 2: STEP Home support

1. What difference has your STEP Home support worker/outreach worker (identify name if known) made in your life?

Theme 3: Health/Well-being, Relationships, Material Situation

1. Please describe any personal changes (positive or negative) that you have experienced over the last 6 months with regard to your health or well-being.

2. Tell me a bit about your relationships over the past 6 months. Have there been any important changes in your relationships during this time?
    a. Changes in relationships with family, friends or acquaintances
    b. Changes in sense of community

Theme 4: Hopes for the Future

1. What are your plans for the coming months or further in the future?
    a. Housing aspirations
    b. Social/relationship aspirations (e.g. reconnecting with family/friends; getting involved in the community; forming new relationships)
    c. Occupational/work/school aspirations
    d. Other personal aspirations

2. What do you need to accomplish your future plans or aspirations?

Concluding Remarks

Before we bring this interview to a close, I would like to ask if there is anything you wish to add about what you life has been like in the past 6 months.

I would also like to know about your experiences (how you feel, what you are thinking) about having participated in this interview today/tonight. What was it like for you to participate in this interview?

Is there anything we could do to improve the interview?

I am now shutting off the recorder. What questions do you have of me?

Thank you very much for your participation in this interview. I appreciate your willingness to share your experiences with me.

Appendix I. Direct Support Worker Focus Group

1. **Outreach Worker Relationships**
   a) What are some of the challenges and successes you have experienced in building relationships with the people you support?
   b) How does the quality of your relationship with the people you support impact housing aspirations, quality of life, etc.?

2. **Barriers to Housing**
   a) Why, if at all, are there delays or barriers to housing some participants?
   b) How can these barriers be addressed moving forward?

3. **Housing Choice**
   a) What are the difficulties or successes in obtaining the types of housing in the locations that participants want?
   b) How can these challenges be addressed moving forward?

4. **Rehousing**
   a) What are the challenges or successes experienced in rehousing some participants (e.g. if someone is not happy with current housing; after eviction)?
   b) How can these challenges be addressed moving forward?

5. **HAWS Program**
   a) How has the HAWS program impacted housing goals/aspirations for the people you support?

6. **Landlord Relationships**
   a) What are the challenges or successes with respect to developing a positive, working relationship with landlords?
   b) How can these challenges be addressed moving forward?

7. **Additional Challenges/Successes**
   a) What other challenges or successes would you like to discuss?
   b) How can any challenges be addressed moving forward?

Appendix J. Correlation Matrices of Outcome Measures at Baseline and Six-Month Follow-up

Correlation Matrices of Outcome Measures at Baseline and Six-month Follow-up

Variable	QOL	FS	MCAS	SSS - Not Including OW	SSS - Including OW	PHQ
QOL		0.196	.699**	.463**	.426**	.575**
FS	.336*		0.199	0.267	0.231	.330*
MCAS	.659**	.412**		.414**	.399**	0.089
SSS - Not Including Outreach Support	.663**	.281*	0.374**		.857**	0.098
SSS - Including Outreach Support	0.351**	-0.096	0.185	.626**		0.152

* p < .05 (2-tailed) **p < .01 (2-tailed)

Note: shaded area represents correlations at 6-month follow-up

Appendix K. Observed and Potential Range on Outcome Measures at Baseline and Six Month Follow Up

Observed and Potential Range on Outcome Measures at Baseline and Six Month Follow Up

	Number of Items	*Potential Range*	*Observed Range*	
Outcome Measure			*T1*	*T2*
Quality of Life (QOL) Scale	20	20 - 140	25 - 123	20 - 122
Multnomah Community Ability (MCAS) Scale	14	14 - 70	19 - 60	15 - 56
Food Security (FS) Scale	9	9 - 21	9 - 21	9 - 21
Informal Social Support (SS) Scale	5	5 - 20	2 - 20	6 - 20
Total Social Support (SS) Scale	5	5 - 20	3 - 20	6 - 20
Perceived Housing Quality (PHQ) Scale	10	10 - 50	n/a	23 - 50

Appendix L. Scoring of Outcome Measures

Items on each scale were summed to give participants a total score on each psychometric instrument. The following items were reverse scored to ensure that a high score on each measure represented a positive outcome.

Outcome Measure	*Reverse Scored Items*
Social Support (SS) Scales	I have family and friends who help me feel safe, secure and happy.
	There is someone I trust whom I could turn to for advice if I were having problems.
Multnomah Community Ability (MCAS) Scale	How successfully have you managed your money?
	How well have you managed day-to-day tasks on your own?
	How frequently have you gotten together with other people?
	How well have you gotten along with other people?
	How large a group of people do you currently know?
	How often have you been involved in activities that were satisfying to you?
	How often have you taken your mental health medications just as they were prescribed?
	Have you been in treatment? If so, how often have you actively participated in your treatment?
Food Security (FS) Scale	Would you say the food you get is nutritious?
Perceived Housing Quality (PHQ) Scale	How do you feel about how long you will be able to live in your place?
	How do you feel about how affordable your place is?
	How do you feel about how easy it is to contact your STEP Home or outreach worker whenever you need to?
	How do you feel about how much choice you have about whether or not you see your STEP Home or outreach worker?
	How do you feel about the choice you have about the types of housing and support services you receive?
	How would you rate your current home for safety?
	How would you rate your current home for spaciousness?
	How would you rate your current home for privacy?
	How would you rent your current home for friendliness?
	How would you rate your current home for overall quality?