EVALUATION REPORT

The John Howard Society of Thunder Bay's Residential Reintegration Program

john howard society

October 2021

ABOUT US

For more than 90 years, the John Howard Society of Ontario has worked to keep the humanity in justice.

Today we continue to build a safer Ontario by supporting the people and communities affected by the criminal justice system. Our 19 local offices deliver more than 80 evidence-based programs and services focused on prevention, intervention, and re-integration across the province. These range from helping youth develop the life skills that will let them achieve their full potential, to assisting families navigate issues of criminal justice, to providing job training for those leaving incarceration so they can contribute to their community in a meaningful way. We promote practical, humane policies while raising awareness of the root causes of crime and calling on Ontarians to share responsibility for addressing them. Within our criminal justice system, we work toward the fair treatment of all. As the system evolves to reflect our changing society, we ensure that no one is left behind.

We believe that policy should be grounded in the day-to-day reality of the people it impacts. That's why our Centre of Research & Policy specializes in bridging the gap between analysis and frontline service delivery. By collaborating closely with our local offices, the Centre's team of analysts and researchers develops policy positions that truly reflect the needs of each community, advances those positions to governments and other organizations, educates the public on the critical issues, and evaluates program efficacy to guide future work. Through it all, they're committed to ensuring that innovative ideas can translate into real action.

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ABBREVIATIONS

BVSP	Bail Verifications and Supervision Program
CSC	Correctional Services Canada
IMS	Information Management System
JHS	John Howard Society
MAG	Ministry of the Attorney General
MoU	Memorandum of Understanding
ODSP	Ontario Disability Support Program
ONWA	Ontario Native Women's Association
OW	Ontario Works
RAP	Resident Action Plan
REB	Research Ethics Board
RRP	Residential Reintegration Program
the Centre	Centre of Research & Policy at the John Howard Society of Ontario

EXECUTIVE SUMMARY

The Residential Reintegration Program (RRP) is a 47-bed transitional housing facility in Thunder Bay that predominately supports individuals who have ongoing criminal justice matters (e.g., released on bail or parole). This report presents the final findings from a process and outcome evaluating of the program. The data informing this report was collected between November 2018 to July 2021. In total, 56 residents consented to the evaluation, with over a dozen quantitative and qualitative methods deployed to answer a variety of process and outcome-oriented questions. The process evaluation focused predominately on whether RRP effectively targeted the appropriate population for its program, and whether its Recreational Therapy and Social Navigator components were implemented effectively. The outcome evaluation focused on the outcomes experienced by residents at RRP, mainly: how many secured housing in the community upon exit; improved their understanding and access to services; bolstered their independent living skills and reduced their risks of homelessness and criminal justice involvement.

Process Findings

The RRP has demonstrated the ability to target both homeless and criminal justice populations. Through the process evaluation, the RRP reached its' target population. The RRP also provided the opportunity to set goals upon entering the program and working on those goals through the Recreational Therapy and Social Navigator component. Some key findings are as follows:

- About 47% of residents experienced homelessness in the past 12 months.
- About 95% had previous criminal justice-involvement.
- 63% were Bail Verification and Supervision Program (BVSP) clients.
- Residents resided for about seven months, on average, with males and Indigenous residents averaging longer stays.
- Residents set a total of 116 goals, with over 50% related to either education (18%), mental health and addiction (17%), and/or employment (16%).
- Residents participated in a total of 330 recreational therapy activities between December 2018 to December 2020. There were over 700 instances of participation.
- The Social Navigator transitioned 16 residents into housing in the community, and successfully connected with residents 169 times in the community.

The program had robust intake and onboarding procedures driven by a client-centred approach. As a result, the program received *Full compliance* for measures related to the following best practices on the evaluation's fidelity checklist:

- Assisting clients to clarify and articulate their important values, challenges, and strengths.
- Ensuring that clients drive the process of identifying goals that are right for them.
- Prompting clients to determine the best course of action and to take action when ready.

Outcome Findings

The RRP evaluation also assessed the outcomes experienced by residents in the program. Some key findings include:

- 40% of residents that left RRP were able to secure some form of housing upon exit.
- Analysis of the pre-post tests found residents were significantly more confident in accessing services in the community in their follow-up compared to when they started at RRP; (t (14) = 2.78, $p < 0.05$), Cohen's d=0.89.
- Residents showed an increased acceptance of needing support and services, whether from staff, friends, or family. The most sought-after support was for substance use and mental health.
- Residents felt a sense of safety and comfort living in the residence; they were able to focus on their mental well-being and developed a sense of resiliency.
- Residents scored higher on follow-up assessments when asked about managing life demands, suggesting an improvement in their ability to manage external stressors and to regulate their own emotions while at RRP.
- Cultural activities had a significant impact on residents, allowing them to take the time to learn more about themselves and re-connect with their culture.
- Residents actively worked on and were successful in obtaining employment during their involvement, and some were able to obtain their high school diploma and other educational certificates.

Challenges

During the course of the evaluation, the RRP faced many challenges related and unrelated to the COVID-19 pandemic. COVID-19 severely impacted residents' access to programming as the residence went into critical operations; residents were unable to congregate in common areas, recreational activities were put on pause, and access to external agencies and supports were limited for the first few months. The main challenges as it relates to COVID-19 are as follows:

- Recreational activities declined and had to take place virtually or while maintaining social distancing. Residents were reluctant to join existing activities, and experienced boredom and "dead space".
- The stability of residents within the program was affected and resulted in a large turnover rate for residents.
- Residents felt isolated from family, friends, their community, and their culture. This was especially difficult for those leaving correctional institutions.

Other challenges that were not a direct result of COVID-19 include:

- There were limited resources to address resident needs as they were too complex to be adequately addressed by the program, such as mental health, and substance use and addictions.
- Residents who were BVSP clients were often breached through the program ending their residency.

In addition, the evaluation, overall, faced challenges and barriers directly and indirectly as a result of COVID-19. These include:

- All data collection was put on hold when the COVID-19 pandemic began.
- Data collection tools designed for the evaluation did not include qualitative measures, and not all tools were relevant to program activities.
- The frequency and number of data collection tools were burdensome to staff, which was further challenged by staff turnover and inability to onboard new staff during the pandemic.

Recommendations

Through the challenges and lessons learned through the evaluation, the Evaluation Team developed some recommendations for future service delivery and evaluations. The key program delivery recommendations include:

1. Increase Number of Program Staff
2. Expand Access to Support and Resources In-House
3. Expand and Improve Access to Recreational Therapy Activities

The key evaluation recommendations include:

1. Develop Evaluation Training Resources
2. Implement Qualitative Tools at Evaluation Start
3. Flexible and Relevant Data Collection Instruments

Overall, RRP effectively engaged with its target population, implemented the Social Navigator and Recreational Therapy components wit high fidelity to its' client-centred case management model. COVID-19 derailed program delivery which invariably impacted RRP residents' ability to work towards their goals. Despite these challenges, a considerable share of RRP residents experienced successful outcomes in securing housing, improving their emotional regulation, and building confidence in accessing supports in the community to address their needs.

1. INTRODUCTION

This report presents the findings of a three-year process and outcome evaluation for the Residential Reintegration Program (RRP) operated by the John Howard Society (JHS) of Thunder Bay. The RRP is a 47-bed transitional housing facility in Thunder Bay that predominately supports individuals who have ongoing criminal justice matters (e.g., released on bail or parole). The Centre of Research & Policy at the John Howard Society of Ontario, hereon referred to as the Centre, was funded through the Ontario Trillium Foundation's Local Poverty Reduction Fund (LPRF) to conduct a process and outcome evaluation of RRP. This final evaluation report presents findings on data collected between November 2018 and July 2021.

The analysis we, the Evaluators, provide below is conducted under a realist evaluation framework. Under this framework, our evaluation is structured to ask, "*what works for whom in what circumstances*," rather than "*does RRP work?"*[1] Ultimately, this report aims to contribute to Ontario's 10-year plan to end chronic homelessness by illuminating what works for youth, women, and Indigenous peoples leaving provincial correctional institutions.

This final evaluation report contains five sections. This introduction section outlines the context in which RRP is situated, and a description of the RRP, its logic model and theory of change. The second section of this report outlines the methods deployed for answering the evaluation questions, including the necessary pivots in data collection due to COVID-19. The third section presents the process and monitoring findings. These findings examine the types of services and supports that RRP clients received and engaged with, as well as program satisfaction. The fourth section examines whether these services and supports led to the following outcomes for residents: an increased awareness amongst RRP residents of supports available in the community; an improved ability to live independently; and a reduction in housing precarity and likelihood of further criminal justice involvement amongst RRP residents. Lastly, the fifth section of this report concludes by reflecting on the findings from this evaluation, and delivers recommendations to assist the program, RRP's stakeholders, and any future evaluations.

1.1. Context

Thunder Bay has exceptional challenges when addressing homelessness and criminal justice interaction compared to other towns and cities across Ontario. Thunder Bay is situated in Northern Ontario and is surrounded by more rural populations and towns. Approximately 37% of the population in Northern Ontario lives in rural communities, defined as an area with a population of less than 1,000 people. In contrast, rural communities comprise 14% of Ontario overall[2] As a city with surrounding rural populations, Thunder Bay operates as a hub for remote and fly-in First Nations communities to access medical appointments and other necessary supports such as housing — especially during the pandemic.[3] While accessing these services and support, both pre-

[1] Hewitt, Gillian, Sarah Sims, and Ruth Harris. "The Realist Approach to Evaluation Research: An Introduction." *International Journal of Therapy and Rehabilitation*, 19.5 (2012): 250-259.
[2] *Northern, rural, and remote child welfare practice.* OACAS Library Guide: https://oacas.libguides.com/c.php?g=710398&p=5063055.
[3] Jeff Walters. "Travel to and from remote, northern First Nations increasing." *CBC News,* 23 September 2020, https://www.cbc.ca/news/canada/thunder-bay/northern-ontario-first-nations-travel-increase-1.5734531.

pandemic and following, individuals may stay longer than anticipated as they need more services than what their community can offer or they may come into contact with the criminal justice system while on a medical visit. The RRP operates in a city which acts as both a corridor for service delivery to rural and remote communities, as well as dealing with its own unique social residents.

Thunder Bay also has unique demographic and social challenges relative to the rest of Ontario. There are substantial gaps in knowledge about the Indigenous population in Thunder Bay, as the Indigenous population is significantly undercounted by official Statistics Canada figures.[4] The 2016 Canadian census reported 9,780 Indigenous adults residing in Thunder Bay. In contrast, the Our Health Counts study used respondent driven sampling methods to estimate that there are between 23,080 to 42,641 Indigenous adults in Thunder Bay—nearly two times the estimate indicated by Statistics Canada.[5] This study found that the Indigenous adult population is much younger than the general adult population in Thunder Bay. Moreover, when compared to other cities in Ontario, the Indigenous adult population in Thunder Bay experiences lower rates of high school completion, as well as higher rates of unemployment.[6]

Alongside these challenges are significant mental health and substance use issues. The Our Health Study estimated nearly 5 in 10 Indigenous adults in Thunder Bay have thought about attempting suicide, compared to 1 in 10 in the entire province of Ontario.[7] Ontario's state of emergency from the pandemic began in March 2020, interrupting data collection for the current evaluation. More importantly, the isolation caused from the pandemic has exacerbated existing mental health concerns, potentially contributing to a recent spike in opioid overdoses in Thunder Bay.[8]

Individuals who are experiencing homelessness are more likely to be in conflict with the law, in part, due to their vagrancy laws and their visibility to policing.[9] Indigenous peoples are over-represented in both the homeless population, as well as the criminal justice population. In fact, nearly 30% of shelter users in Northern Ontario are Indigenous.[10] Relatively little attention has been paid to addressing homelessness in Northern Ontario, where nearly half of Ontario's Indigenous population resides.[11] Most research and interventions directed at reducing homelessness have focused on urban areas, yet rural and remote communities experience homelessness in different and more complex ways.[12]

The colonial legacy, including but not limited to residential schools and the Sixties scoop, also continues to be felt in the Indigenous community in Thunder Bay. Institutionalization has

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[4] Logan Turner. "Indigenous people likely affected by COVID-19 at disproportionate rate in Thunder Bay, but no clear data." *CBC News,* 17 May 2021, https://www.cbc.ca/news/canada/thunder-bay/indigenous-covid-rates-tbay-1.6027643.
[5] Well Living House & Anishnawbe Mushkiki. "Our Health Counts Thunder Bay: Demographics Fact Sheet." Fact sheet. n.d. Web.
[6] Ibid.
[7] Well Living House & Anishnawbe Mushkiki. "Our Health Counts Thunder Bay: Mental Health." Fact sheet. n.d. Web.
[8] Gary Rinne. "Opioid-related overdoses in Thunder Bay area jump by nearly 40 per cent." *Thunder Bay News: tbnewswatch.com,* 8 February 2021, https://www.tbnewswatch.com/local-news/opioid-related-overdoses-in-thunder-bay-area-jump-by-nearly-40-per-cent-3361164.
[9] *Closed Quarters: Challenges and opportunities in stabilizing housing and mental health across the justice sector.* Housing, Health and Justice Community of Interest, February 2019.
[10] Ibid.
[11] Ibid.
[12] Ibid.

continued to impact Indigenous communities in Thunder Bay, as nearly 75% of Indigenous adults in the Our Health Study reported doing some time in prison.[13] Half of these respondents indicated that the services to address the impacts of incarceration in Thunder Bay were inadequate.[14]

While the list of challenges noted above are overlapping and complex, the Thunder Bay community has demonstrated resilience in its responses. In particular, Thunder Bay's public health response to COVID-19 has been lauded for prioritising vaccinations amongst homelessness populations,[15] in response to COVID-19 outbreaks in correctional facilities and homeless shelters.[16]

1.2. Program Description

The RRP is a 47-unit residential facility that provides transitional housing to local men and women aged 18 and older who are in conflict with the law and are either homeless or at-risk of being homeless.

The program targets individuals re-entering the community following a period of incarceration, particularly those who are on remand or would otherwise have their bail withheld (i.e., the period in which they have been charged but not found guilty). Potential residents are referred to the program through lawyers and courthouse coordinators (e.g., for individuals with bail matters). Prior to COVID-19, the RRP accepted walk-ins during the program's weekly open intakes that occurred every Tuesday to Thursday. The intake process was slowed down due to stay-at-home orders and quarantine measures but aligned with lockdown measures as they were reduced and re-introduced. Housing and justice stakeholders in Thunder Bay are aware of RRP through outreach efforts, and word of mouth at the courthouse, treatment centres, and local shelters.

Along with providing shelter, the RRP supplies free breakfast for all participants and clothing is available for immediate provision. The RRP staff also work closely with local foodbanks, community agencies and other services to coordinate access to food and clothing for participants.

Criminal justice involvement and precarious housing are intertwined.[17] By addressing the risks associated with criminal justice involvement, the RRP aims to decrease homelessness in Thunder Bay. The RRP delivers these three key components as a part of its transitional housing program to address criminogenic risks and housing stability:

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[13] Well Living House & Anishnawbe Mushkiki. "Our Health Counts Thunder Bay: Criminal Justice." Fact sheet. n.d. Web.
[14] Ibid.
[15] CBC News. "'A pretty impressive story': Thunder Bay's success in controlling COVID-19 lauded by Toronto Expert." *CBC News*, 6 July 2021, https://www.cbc.ca/news/canada/thunder-bay/thunder-bay-covid-19-july-6-2021-1.6091565.
[16] Willow Fiddler. "Thunder Bay grapples with COVID-19 outbreaks in correctional facilities, homeless populations." *The Globe and Mail*, 24 February 2021, https://www.theglobeandmail.com/canada/article-thunder-bay-grapples-with-covid-19-outbreaks-in-correctional/
[17] See John Howard Society of Ontario. 'Reintegration in Ontario.' (2016). Available at: https://johnhoward.on.ca/wp-content/uploads/2016/11/Reintegration-in-Ontario-Final.pdf & John Howard Society of Ontario. 'Effective, Just and Humane: A Case for Client-Centered Collaboration.' (2012). Available at: https://johnhoward.on.ca/wp-content/uploads/2014/09/effective-just-and-humane-a-case-for-client-centered-collaboration-may-2012.pdf.

1. A client-centred approach to case management;
2. A recreational therapy component; and
3. A Social Navigator.

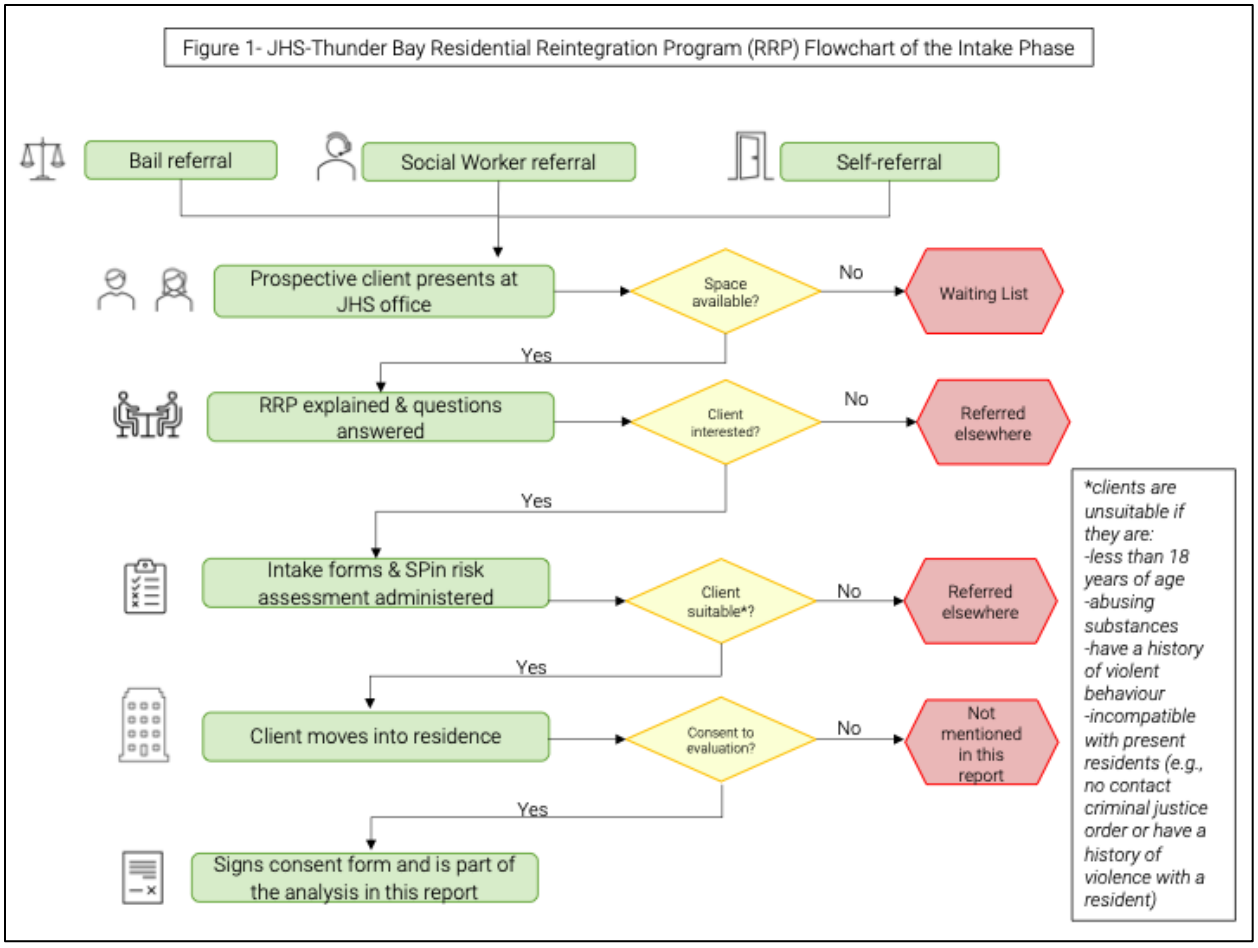
Each of these three components are explained in further detail below.

1.2.1. Client-Centred Case Management Strategy

Beyond providing shelter and the essentials for living, the client-centred case management aspect of RRP is the most crucial intervention of the program. This strengths-based approach draws on the residents' own capabilities to promote an improved quality of life, while providing timely access to essential supports and services. After program admission, residents identify their goals and unmet needs in their Resident Action Plan (RAP), a template of which can be seen in Appendix U. Residents work with their Case Manager in developing a customized plan with skill sets and activities that will improve the likelihood of successful re-entry upon transitioning from the residence to housing in the community. Case Managers utilize information gathered from the intake assessment to assist residents in addressing the underlying factors that contribute to their criminal justice involvement or homelessness. The RRP case management supports are provided to participants throughout their time in the program and are best understood through the following five phases:

Phase 1: Intake, Stabilization and Relationship Building

The resident intake process is important in ensuring smooth onboarding for programming and long-term success. During the intake process, a Case Manager meets with individuals seeking to reside in RRP to explain the program, conduct initial assessments, and perform intake activities (e.g., checking the availability of residence beds). This intake data informs responses to many of the items on the SPIn Risk Assessment, a tool used by RRP staff to understand the strengths and needs of potential clients. RRP staff then assess whether an individual is suitable for the program. The process for determining eligibility may take up to 1 to 2 days. Figure 1 below provides a flowchart of how activities in phase 1 unfold.



The RRP operates on limited eligibility requirements. As an adult transitional housing setting, the RRP does not offer housing to individuals aged 17 years and under. Although the RRP has a handful of accessible units, individuals referred with acute physical and mental health needs are referred elsewhere to more intensive supports. Apart from these two factors (individuals aged 17 and under, those with acute health needs), the RRP takes a variety of potential clients experiencing homelessness, with a special focus on drawing clients leaving criminal justice settings.

For potential clients entering the RRP through correctional institutions, there are eligibility criteria related to provincial and federal justice system programs which invariably impact access to the RRP. For instance, the RRP operates in coordination with the Bail Verification and Supervision Program (BVSP) funded by the Ministry of the Attorney General (MAG), as well as Parole services from Correctional Services Canada (CSC). Individuals who are a part of JHS-Thunder Bay's BVSP services and experiencing homelessness are frequently referred to the RRP, where they reside at the RRP and are supervised by the BVSP. This supervision is guided by the conditions on bail whereby individuals must abide by the conditions on their release order. Such orders invariably impact the residents' life and functioning inside and outside of the residence. For example, RRP residents under BVSP supervision may have conditions stipulating curfews, no substance use, and restrictions on where individuals cannot go such as close to where their offense was committed. Individuals can be breached by the BVSP at any time and cut short their stay and

programming at the RRP. Furthermore, 2 to 11 of the 47 beds may be reserved for federal parole clients. The supervision from the BVSP impacts RRP residents, however, similar to individuals on parole, the supervision component is not within the scope of this evaluation.

Once an individual enters through a referral pathway, the Case Managers at RRP review the suitability of clients for the program. Suitability is a fluid concept, as applicants may not be able to reside at RRP due to a no-contact order with a current resident. However, once that resident moves the applicant may be suitable for RRP. Moreover, Case Managers take various assessments into consideration to determine suitability including: SPIn scale scores; impressions of how cooperative the individual has been throughout the intake process; the degree to which the individual appears open and honest with RRP staff about their needs and suitability for the program; and a review of JHS-Thunder Bay historic files. While the RRP remains a low-barrier housing service in Thunder Bay, these factors help to inform the suitability and well-functioning of the program, ensuring the RRP is a safe and supportive environment for all residents and staff.

Phase 2: Resident Action Plan and SPIn

Once suitability is ascertained, clients move into the JHS-Thunder Bay residence. Case Managers follow up with residents at regular intervals (e.g., immediately, next day, day 3, etc.) over the subsequent 1-2 weeks to monitor progress on how clients are settling in and ensuring that their basic needs are being met. The focus of these meetings is to assess how the clients are coping, what their top priorities are at that moment, what is currently going on in their lives, and any feedback regarding their experience staying at RRP. Most importantly, RRP staff use this time to build a trusting and therapeutic relationship with new residents. Individuals experiencing chronic homelessness are often deemed a "hard-to-serve" client population, as they are unlikely to experience success with previous programs and may be dejected from connecting with services.[18] Developing trust with residents, first and foremost, is vital to the collaborative work between Case Managers and residents. Allowing time for residents to settle and provide feedback is intended to foster trust and work on goals with the resident.

Following a 1-2 week settling in period, Case Managers connect with residents and discuss their goals, both short and long term. Information garnered during these meetings is used to complete any remaining items on the SPIn assessment. Case Managers then discuss resident risks and protective factors as revealed by the SPIn results and work collaboratively to identify goals and engage in relevant activities. These goals and activities are documented in the resident's RAP.

Phase 3: Continued Stabilization

Once the RAP has been created, residents begin participating in life skills programming available either onsite at JHS-Thunder Bay or in the community. If someone is attending school during the week, they may be exempted from attending the life skills programming. Throughout this phase, the residents and Case Managers continue to connect on a frequent basis in a therapeutic way to

[18] Pearson, C., Montgomery, A. E., & Locke, G. (2009). Housing stability among homeless individuals with serious mental illness participating in housing first programs. Journal of Community psychology, 37(3), 404-417.

discuss how they are coping with their release (in the case of community re-integration clients), how they are progressing in achieving their goals, and how they are managing in general.

Phase 4: Stabilization and Program Exit

In this phase, the resident and Case Managers continue to work together but begin to discuss next steps towards leaving the RRP and transitioning to the community. Most residents remain in RRP for a period of three to eight months. There have, however, been outlier cases where residents have remained as long as one to two years. Once residents are preparing to transition into the community, the Social Navigator begins to assist the residents in looking for housing and the essentials required for living independently.

Phase 5: Post-exit Follow-up

Once transition to the community is complete, the Social Navigator follows up with clients in the community on an ongoing basis for a period of one year following program exit in order to track how well they are functioning/managing. The Social Navigator role is described in detail further below.

1.2.2. Recreational Therapy Component

Since most of the residents have been involved in the criminal justice system, they often lack access to and engagement in positive prosocial activities. Recreational opportunities for individuals experiencing homelessness have been shown to improve the quality of life and coping skills.[19] The use of recreational therapy can elevate emotional, physical, and social elements of life, thereby improving the development of community and social skills, empowerment, coping and leisure skills. Service providers at JHS-Thunder Bay report that boredom and disengagement are barriers to successful reintegration among clients. As part of funding provided by the LPRF, a recreational therapy component was introduced to the RRP. The objectives of the recreational therapy were to identify and/or create recreational activities, which encourage clients to pursue new prosocial opportunities. Recreational activities include but are not limited to assembling bicycles, playing musical instruments, and games. Additionally, the Recreational Therapist encourages and facilitates client participation for as many as possible in the RRP.

1.2.3. Social Navigator Component

The Social Navigator provides case management and navigation services that assist clients in obtaining housing and employment stability. The Social Navigator is the point of contact for coordinating and liaising with community services, working alongside with clients to determine an

[19] See Knestaut, Melissa, Mary Ann Devine, and Barbara Verlezza. "It gives me purpose": The use of dance with people experiencing homelessness." Therapeutic Recreation Journal 44.4 (2010): 289-301; & De Vries, Dawn, and Andrew Feenstra. "Making the case for recreational therapy services with individuals experiencing homelessness." World Leisure Journal 61.2 (2019): 77-97.

appropriate time to transition to housing in the community, and identifying and securing appropriate long-term housing and community services (i.e., completing paperwork and lease arrangements).

After transitioning to the community, the Social Navigator continues to provide case management services. This includes regular and ongoing follow-up services for up to 12 months, as needed to facilitate successful transition and long-term housing stability. The year of follow up resets where individuals lose their housing and need to be re-housed.

1.3. Logic Model

The three components of the program (client-centred case management, recreational therapy, and social navigation) work in concert to achieve the following objectives:

- Provide immediate access to housing and appropriate resources (clothing, food, etc.).
- Improve the awareness of residents of their own needs and services available to address them.
- Increase resident independent living skills (e.g., cooking, finance, nutrition, goal setting, etc.) and participation in pro-social recreational activities (e.g., sports, games, biking, etc.) through a client-centred approach which works with residents to form goals and participate in activities they wish to pursue.
- Improve resident employability (e.g., through pursuit of education/training).
- Reduce resident risk of criminal justice involvement and criminogenic risks.

These objectives are documented as short & mid-term outcomes in the Logic Model below. Short-term outcomes are those whose achievement will facilitate the achievement of mid-term objectives. Long-term outcomes specified in the Logic Model represent accomplishments that are expected to emerge in a time frame outside of the scope of this evaluation, therefore, will not be directly assessed in this report.

Figure 2: JHS-Thunder Bay Residential Reintegration Program Logic Model

Inputs

Physical Resources
- *47 bed adult facility*:*
- 9 beds for females
- 36-45 beds are part of the evaluation (dedicated bail beds & community integration)
- *2-11 beds used for CSC (federal) clients—not a part of this evaluation

Human Resources
- 1 Training & Development Manager
- 1.5 RRP Case Managers
- 1 Recreational Therapist
- Part-time Data Entry Assistant
- Night Security Staff (5 + Causal Pool)
- Custodian/Maintenance

Coordinated Community Partnerships

Referral Agencies:
- BVSP, Thunder Bay Correctional Centre (TBCC), & drop-in

Service Partners:
- Employment & mental health providers

Other Supports:
- Transportation via bus tickets & agency van.
- JHS-Ontario evaluation
- Food via breakfast & foodbank
- Clothing via emergency provision & Value Village

Activities

Outreach
- Primary source of referrals through word of mouth; Social Workers at TBCC & drop-in from community (Tuesday-Thursday)

Intake & Assessment
- Intake Tool & Resident Action Plan (RAP) developed within first two weeks based on results from SPIn & self-generated goals by clients
- 1-to-1 Case Management supports for anger management, life-skills, & at times recreational therapy

Group Programming
- Life skills programs & activities (e.g., anger management, budgeting, etc.,)
- Based on need & updated on-going basis

Recreational Therapist
- Prosocial activities (e.g., boxing, gym partnerships, art programs, gardening).
- Cultural activities (e.g., smudging)

Social Navigator
- Assist clients with transitioning into housing in the community
- Life skills programming
- Connection to services in community
- Follow-up in the community (informal check-in)

Community Coordinating
- Referrals to partner agencies
- Partners provide programming inside residence (e.g., employment, mental health, etc.,)

Outputs

Participants
- # receive access to housing
- # engage in prosocial/psychosocial programs
- # of intakes, RAPs, & SPIn assessments

Recreational Therapist (Group Statistics)
- # & type of activities
- Attendance in programs

Social Navigator
- # of clients engaged;
- # of meetings with clients
- # of follow-ups
- Engagement with landlords (qualitative)

Residence
- # of beds occupied
- # of serious occurrence reports

Community
- # & type of drop-in activities delivered for the community by Recreational Therapist
- Stakeholder Satisfaction
- Evaluation report(s)

Short-& Mid-Term Outcomes
(6 months to 2 years)

Participants experience improvements in:

Access to Immediate Housing Supports

Awareness of Needs & Services
- Housing, Mental & Physical health
- Where to receive supports

Independent Living Skills
- Coping & life skills

Protective Factors from Crime
- Engagement with recreational activities
- Attaining employment & education

Reducing Criminogenic Risk

Community
- Networking with agencies working in the sector
- Cross-programming & collaboration between different stakeholders

Long-Term Outcomes
*(3 years+)***

Contribute to Poverty Reduction Strategy Indicators:
- Reduction in long-term unemployment in Thunder Bay
- Reduction in the # of youth (18-29) not in education, employment or training (NEET)
- Reduction in poverty rates of vulnerable populations
- Reduction in youth homelessness and homelessness following transitions from provincially-funded institutions
- Reduction in chronic homelessness in Thunder Bay

**outside of the scope of this evaluation

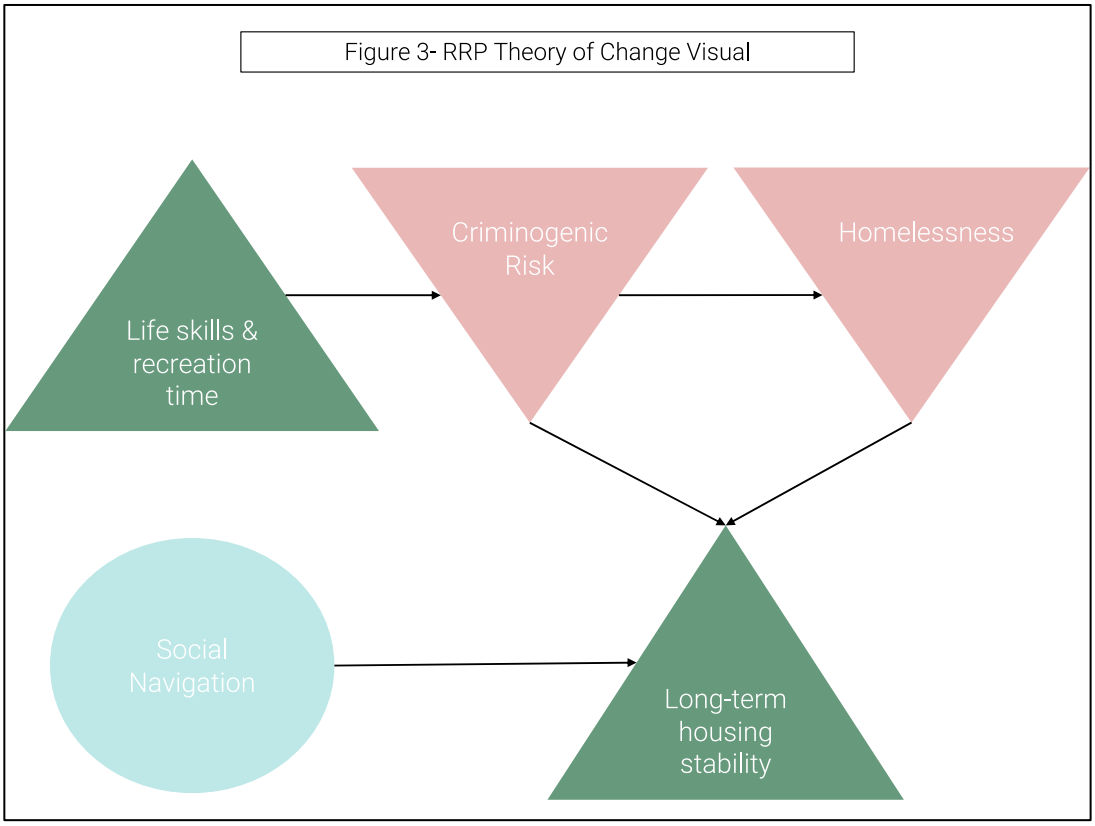
1.4. Theory of Change

While there is no single general theory underlying the RRP, its development has been largely influenced by sociological theories such as the General Strain Theory,[20] and Self-Control Theory of Crime,[21] which postulate that the interactions between individual and societal forces contribute to criminal behaviour. With the risk of crime reduced, it is assumed that this will also ultimately lead to diminished homelessness.

The RRP aims to provide a holistic and client-centred approach that equips people with the resources and skills necessary to achieve important goals without involvement in the criminal justice system. It uses a self-determined and strengths-based approach, utilizing an empowerment framework to identify and address appropriate needs and protective factors of individuals. It applies a relatively intensive approach in guiding individuals through the community reintegration process, including connection to housing, employment, and other services. There are regular follow-ups in hopes that the individual is maintaining their ability to live independently.

The underlying model driving the RRP can be depicted as seen in Figure 3 below.

Figure 3- RRP Theory of Change Visual



[20] Agnew, R. Foundation for a general strain theory of crime and delinquency. Criminology 30 47–87. (1992). http://dx.doi.org/10.1111/j.1745-9125.1992.tb01093.x

[21] Gottfredson, M. R., & Hirschi, T. (1990). A general theory of crime. Stanford, CA: Stanford University Press.

In Figure 3, the direction in which the triangles point suggests where the program is aiming to make an impact for residents. The green triangles which point upwards notes the factors the program is trying to increase for residents, while the red triangles which point downwards indicate the factors the program is trying to reduce for residents. As noted earlier, homelessness and criminogenic risk are intertwined, whereby the presence of one factor is frequently correlated with the other. The RRP operates under the assumption that by reducing criminogenic risks and providing immediate housing individuals will be more likely to transition towards long-term housing stability. For example, it is expected that improved life skills and more effective use of leisure time will directly lead to a decrease in the risk of crime, and thereby reduce the risk of losing housing and experiencing homelessness. By addressing the need of RRP residents, their criminogenic risks, and providing transitional housing it is hypothesised that the RRP will ultimately contribute to decreased homelessness in Thunder Bay.

2. METHODOLOGY

2.1. Evaluation Design

This evaluation utilizes a mixed-methods design to capture both quantitative and qualitative measures related to the Residential Reintegration Program's (RRP) processes and outcomes. By adopting both quantitative and qualitative methods, the Evaluation Team sought to triangulate findings across various methods, thereby strengthening the validity of the findings.[22] Deploying more research methods does not equate to more validity. Nevertheless, the Evaluation Team implemented a mixed-methods design to leverage the strengths provided by both quantitative methods (i.e., for summary and probability), and qualitative methods (i.e., inductive and exploratory).

Surveys and client tracking forms instruments were applied at regular intervals to capture quantitative data. Section 2.3 of this report summarises the various tools created by the Evaluation Team and the sample sizes obtained from each instrument in this evaluation. The Evaluation Team also utilized data from RRP's existing data collection processes, such as the case notes and residence tracking processes implemented by RRP staff. The quantitative instruments were a combination of repeated measures, such as the pre and post-test assessment, and one-shot scales, such as the closed-ended satisfaction survey questions.

The impact of COVID-19 necessitated incorporating a more qualitative approach to the evaluation design. Data collection came to a stand-still once a state of emergency in Ontario was declared on March 17, 2020. The transient nature of homeless populations provides challenges in securing, isolating, and contract tracing individuals who are shifting in and out of community settings.[23] Once the pandemic began, the priority for the program centred on ensuring the safety of staff and clients. Data collection became a liability for the safety of staff and residents, as face-

[22] Greene, Jennifer, and Charles McClintock. "Triangulation in evaluation: Design and analysis issues." Evaluation review 9.5 (1985): 523-545.

[23] https://www.canada.ca/en/employment-social-development/programs/homelessness/directives.html

to-face interviews and data collection could not ethically continue or be considered essential under the circumstances. The RRP also focused its attention closer to public health initiatives, widening the breadth of the intervention, while impacting the delivery of services.

In response to these circumstances, the Evaluation Team developed semi-structured interview guides for staff and residents. These interviews provided rich insight into how RRP adapted once the pandemic began, as well as residents' thoughts on RRP. Ultimately, the combination of quantitative and qualitative methods ensured the Evaluation Team gained an understanding of where the program was or was not producing outcomes as well as possible explanations for how.

2.2. Evaluation Questions

This evaluation is structured around answering 33 questions, 23 of which relate to program processes with the remaining 10 centred on client outcomes. The process evaluation answers 23 questions related to RRP's implementation. More specifically, these questions can be organized into four distinct subcategories: (1) resident profile; (2) the program services and supports delivered; (3) program satisfaction; and (4) sustainability of the program. The process evaluation questions are presented below. For more details on the sources of data used to answer these questions refer to the Process Evaluation Matrix in Appendix A.

Resident Profile

1. Did RRP accurately identify and deliver services to the target population?
2. What were the demographic characteristics of the participants?

Program Services & Supports Delivered

3. To what extent is the residence being utilized?
4. Did residents receive access to housing and resources?
5. To what extent did residents participate in activities/programming?
6. To what extent did residents participate in recreational opportunities?
7. What goals were most common amongst participants?
8. Did residents engage in psychosocial programming as specified in their RAP?
9. Did the Case Manager implement a client-centered approach appropriately?
10. Did the Social Navigator provide the intended services for participants exiting the program?
11. Did the Recreational Therapist provide the intended services?
12. In what ways did COVID-19 impact residents' involvement in the program and access to programming and services?

Program Satisfaction (Residents & Stakeholders)

13. Were residents satisfied with the intake process (including orientation and move-in)?
14. How satisfied were residents with the life skills programming?
15. How satisfied were residents with the recreational therapy activities?
16. What were residents' perception of the program? What worked/didn't work? What were facilitators/ barriers? What did they like best/least?
17. How satisfied were community partners with the program overall?
18. How satisfied were community partners with the referral process?
19. Did RRP effectively engage partners in coordinating service delivery planning?
20. Did RRP increase partnerships/relationships with landlords?
21. Did RRP increase formalized partnerships with other community agencies to deliver on-site services?
22. In what ways did COVID-19 impact community partners' involvement with RRP?

Sustainability of the Program

23. Does the program have a plan for sustainability?

The outcome evaluation answers 10 questions related to program outcomes for residents of RRP. The outcome evaluation centres on impacts experienced by residents at the individual level, as opposed to outcomes for the program overall or community at-large. The evaluation anticipated the RRP would produce outcomes in the following areas for clients: access to immediate housing supports; increased awareness of needs and services; improve independent living skills; bolster protective factors against crime; reduce criminogenic risks. The 10 outcome evaluation questions are presented below. For more details on the sources of data used to answer these questions refer to the Outcome Evaluation Matrix in Appendix B.

Access to Immediate Housing Supports

1. Did residents maintain safe and permanent housing following their stay at RRP; and at follow-ups?

Increased Awareness of Needs & Services

2. Did residents have an increased understanding and acceptance of their own needs and issues?
3. Did residents show increased awareness in how to obtain needed community assistance such as mental health, employment, and relationships guidance?

Improve Independent Living Skills

4. Did residents show improved coping and life skills?
5. Did residents improve their ability for living independently?

6. Did residents show improvement in self-efficacy, social support, and mental well-being?

Bolster Protective Factors

7. Did residents improve their awareness of the benefits of, and their motivation to participate in, recreational opportunities?
8. Did residents find and maintain employment (or other forms of sustainable income), for 6 months or more?
9. Did residents improve their educational status?

Reduce Criminogenic Risk

10. Did residents reduce overall risk levels for criminal justice involvement?

COVID-19 created an existential health crisis for program staff and residents, necessitating unforeseen activities in RRP (e.g., enforcing protective health measures in congregate settings, reducing the negative effects of isolation, etc.,). The Evaluation Team conducted interviews and reviewed case files to capture how COVID-19 impacted resident outcomes. The Evaluation Team's effort falls short of a thorough analysis of how COVID-19 impacts transitional housing settings. Nonetheless, this report provides insight as to how resident outcomes were stunted and revealed the unique challenges RRP residents face when confronted with a severe public health issue such as a pandemic.

2.2. Data Collection & Sample

Data collection for this evaluation included multiple instruments which incorporated quantitative and qualitative measures. Residents, staff at RRP, and stakeholders of the program are the three sample groups informing this evaluation. Data collected from residents was primarily through their case files, tracking forms filled by RRP staff, self-reported questionnaires, and interviews. The Evaluation Team also invited core RRP staff team members from JHS-Thunder Bay to participate in informal interviews to share their experiences and provide feedback about the program. All of the core staff were asked similar questions regarding the program activities, as well as challenges and opportunities for RRP. Stakeholders of RRP were asked to complete an online survey.

Data collection began in November 2018 and ended July 2021. For a detailed description of the instruments used in the evaluation see Appendix F. In total, 56 residents signed consent forms to participate in this evaluation. Accurate data on the number of residents who were eligible for the evaluation but refused is not available, as COVID-19 interrupted data collection. Therefore, an accurate response rate cannot be calculated for this evaluation, nor can the Evaluation Team say with certainty the degree to which the responses presented here are representative of the

residents' experiences in the program. Lastly, the evaluation was able to interview 7 RRP staff, and received 14 responses from stakeholders in the survey.

Figure 4 visualizes the data collection for RRP residents over the course of the evaluation. The graph outlines data collection over fiscal quarters (calendar year) and highlights how COVID-19 impacted data collection. Recruitment for participants was anticipated to occur throughout the course of the program as new residents moved into RRP. The first influx of evaluation participants occurred in the evaluation's first year between November 2018 to December 2019. During this time, the Evaluation Team was able to recruit 42 residents to participate, reaching more than half of its target of 75 in the first year. COVID-19 stunted any chance of further recruitment in the evaluation as health and safety protocols drastically reduced the number of RRP staff, and in-person meetings where the evaluation could be explained. Despite the inability to recruit participants through much of the pandemic, the Evaluation Team was able to connect remotely with some residents. Data collection for this evaluation concluded in July 2021, and the Evaluation Team was able to recruit a total of 56 residents, reaching 74.66% of its target of 75 participants.

Figure 4: Data Collection TImeline for RRP Residents

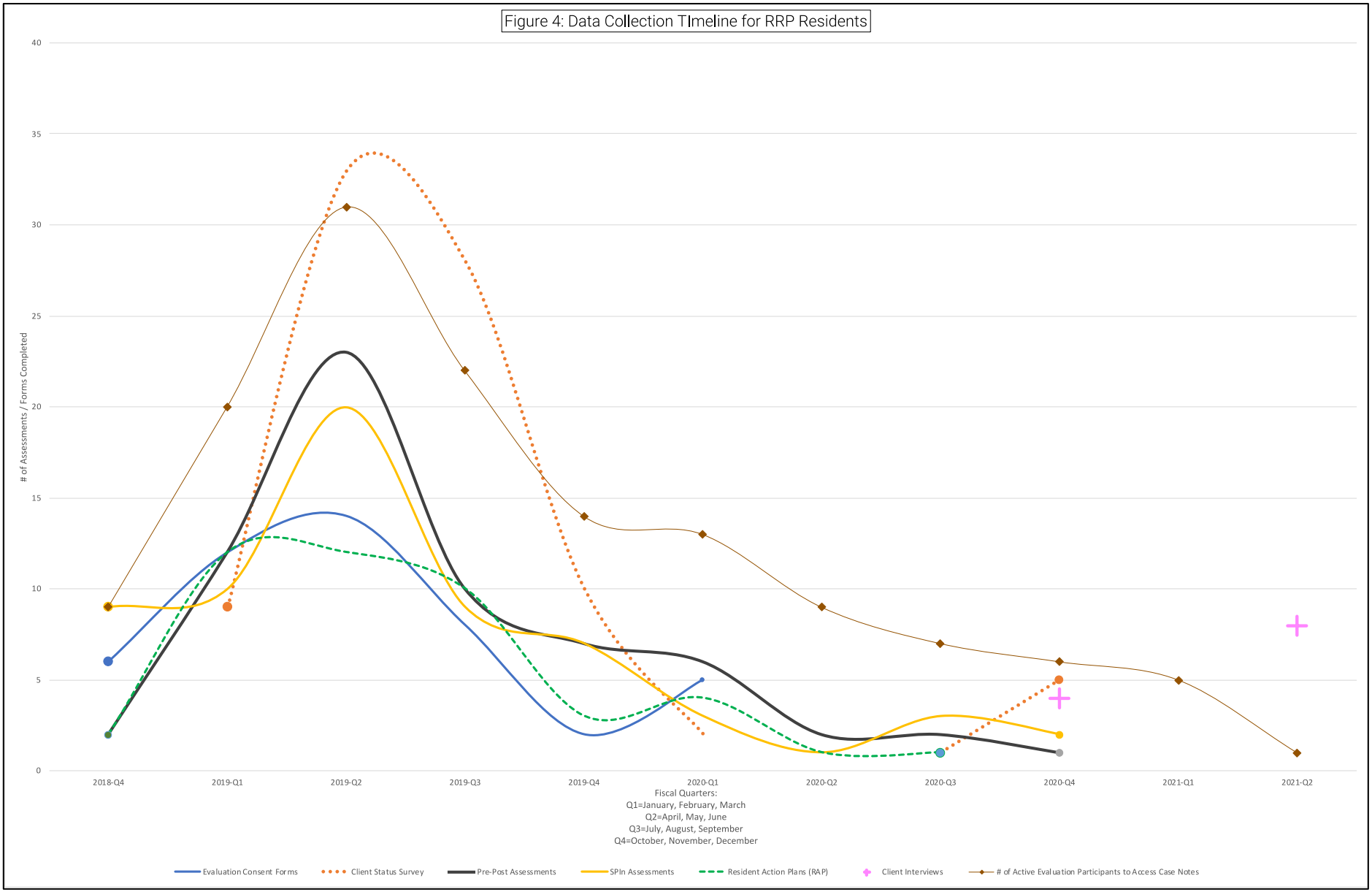


Table 1 below provides further details of the sample size obtained for residents. Table 1 shows wide variation in engagement with the evaluation, as few satisfaction surveys were completed by residents and not all residents completed a RAP. A significant portion of the data on residents relied on the information inputted by RRP staff, such as the program tracking, attendance forms, and case notes review. Table 1 also provides further detail on the impact of COVID-19, as much of the data was collected prior to March 2020 and the onset of the pandemic. The subsequent section details how this changed the data analysis plan and the response from the Evaluation Team.

Table 1: Evaluation Instruments & Sample Summary for Residents

Instrument	Description	Collection Period		Sample
		Earliest Entry	Latest Entry	
Evaluation Consent Form	Informs client of the evaluation study, the use and treatment of their data, and a reminder of their rights.	November 5, 2018	May 31, 2021	56 residents
Intake Form	Collects demographic and social information on residents	November 5, 2018	July 21, 2020	56 residents
Attendance & Program Tracking Forms	Tracking participation from residents in program activities	November 20, 2018	November 20, 2020	374 entries
Case Notes	Notes from staff regarding interactions with residents	November 5, 2018	July 2021	56 residents
SPIn Risk Assessment	Assessed risks and needs of residents	November 5, 2018	October 2, 2020	56 residents
Resident Action Plan (RAP)	Set out residents' goals and planned activities while participating in RRP	November 28, 2018	August 31, 2020	46 residents
Resident Tracking Sheet	Updated weekly to track a running tally of the number of individuals residing in the building and those on the waiting list.	November 5, 2018	December 31, 2020	67 entries
Social Navigator Activities Form	Updated weekly by the Social Navigator to track their key activities.	December 9, 2019	December 19, 2019	31 entries
Recreational Therapist Activities Form	Updated monthly by the Recreational Therapist to track their key activities.	January 2019	December 2020	376 entries
Client Status Survey	Brief survey that examined how well the resident is faring at monthly scheduled meetings.	June 10, 2019	September 28, 2019	88 entries from 33 residents
Client Satisfaction Survey	Annual survey which assessed the resident's experience with the program and how to improve it.	April 30, 3019	June 25, 2019	9 surveys
Pre-Post Assessment	Measured a suite of psychological, behavioural and attitudinal variables. Assessed change over time, at intake, exit, and at post-exit follow-up sessions	December 12, 2018	August 31, 2020	66 in total (45 at intake; 10 at exit; 11 at post-exit)
Interviews	One-to-one interviews with residents to learn about their experiences at RRP.	November 2020	June 2021	12 interviews with 10 residents

2.3. Data Analysis

COVID-19 affected the data collection, which had a trickle-down effect on the analysis planned for the evaluation. Initially, the Evaluation Team intended to analyze the residents as a single sample. Being mindful of the selection effect, the analyses would be compared between participants depending on their length of stay. Then on March 17, 2020, Ontario declared a state of emergency, and this watershed moment affected all lives, employers, and programs across the province. Such a significant event altered the experience of the Residential Reintegration Program (RRP); specifically, their intake processes and activities occurring inside the residence. The experience of residing in RRP was categorically different for individuals who lived there before March 17, 2020, and those who remained or moved in after the emergency measures came into effect. The Evaluation Team implemented two solutions to account for the impact of COVID-19. The first was to compare resident profiles, experiences, and outcomes through cohorts. The second solution was to do a deeper qualitative analysis of the resident's case notes, since new recruiting evaluation participants and collecting was halted for long periods. The following sections unpack the reasoning behind both decisions and where these decisions affected the evaluation.

Cohorts

The Evaluation Team had to not only consider that more data had been collected from residents prior to Ontario enacting emergency measures, but also that the experience for RRP residents—and the profile of those who left, stayed, or entered later—was likely different. Unpacking these potential differences became a critical question that made it unreasonable to analyze all 56 residents who consented to the evaluation as if they all experienced the same intervention. Given these circumstances, a decision was made to examine two presumptions.

The first presumption relates to the selection effect, specifically, that there may be three different types of residents who participated in RRP. One cohort of residents could be categorized as individuals who left RRP before the onset of COVID-19. A second cohort could be conceived as individuals who entered RRP before the onset of COVID-19 but remained in the residence after the emergency orders. This second cohort would have the unique perspective of recalling how RRP functioned before and after the onset of COVID-19. Finally, a third cohort could be seen as individuals who entered RRP only after the emergency orders came into place. This third cohort may have different thoughts on RRP given they had no experience of the program prior to COVID-19. The selection effect looms heavily over the analysis in this report, since this is not a randomized control trial and individuals voluntarily enter RRP. Individuals choose their length of stay in the residence—even those in the BVSP can choose to breach their bail conditions and leave the residence early if they wish. By analysing respondents across the three cohorts the evaluation aims to account for some of this agency of the residents at RRP, particularly for those who chose to stay during the pandemic. Table 2 on the following page provides an overview of the number of residents who have been categorized under each of the three cohorts.

The second presumption the Evaluation Team needed to examine is whether the three cohorts outlined above did in fact experience a different version of RRP before and after COVID-19. The impetus here is to go beyond a prima facie understanding that COVID-19 changed how RRP operated. Particularly for the process and monitoring findings, the Evaluation Team has examined any differences between the three cohorts in their level of engagement with the Recreational

Therapist and Social Navigator. Resident engagement is both a function of their choice to participate, and the nature of these services before and after COVID-19. The Evaluation Team examined engagement with the services across the cohorts, and where applicable provided a narrative to explain how services adapted to the pandemic, thereby contributing to the change in engagement. The Evaluation Team examined differences between the cohorts predominately through chi-square tests on various demographic and social factors, the results of which can be found in the process and monitoring section.

Table 2: Breakdown of Residents by Evaluation Cohorts			
Cohort	Description	n	%
1	Entered & exited RRP prior to March 17, 2020, when Ontario declared a state of emergency.	35	62%
2	Entered RRP before Ontario declared a state of emergency on March 17, 2020 but remained in the residence once emergency measures were in place.	14	25%
3	Entered RRP after Ontario declared a state of emergency on March 17, 2020.	7	13%
Total		56	100%

Case Note Coding

As noted above, the onset of COVID-19 halted recruitment and data collection for this evaluation. Anticipating a substantial reduction in data collection, the Evaluation Team altered its analysis plan by deploying qualitative methods that offered more flexibility than surveys. First, the Evaluation Team conducted remote evaluation consents for new residents and one-to-one interviews. Residents who consented to the evaluation also allowed access to their case notes for the purposes of the evaluation. Access to the case notes of all 56 residents who consented to the evaluation provided in-depth information on residents and their interactions with staff. Table 3 provides an overview of the number of pages of case notes that the Evaluation Team reviewed, and the mean number and median number of pages of case notes per resident.

Table 3: Total Number Pages of Case Notes Coded for the Evaluation				
Cohort	# of Residents	Total # of Pages of Case Notes	Mean # of Pages of Case Notes per Resident	Standard Deviation from the Mean # of Pages
1	35	387 (54%)	11.06	9.24
2	14	257 (36%)	18.36	16.50
3	7	73 (10%)	10.43	7.59
Total	56	717 (100%)	12.80	11.57

The Evaluation Team reviewed and coded 717 pages of case notes in total. Cohort 2, those who entered RRP prior to the onset of COVID-19 and continued to live in the residence during emergency orders, had the most case notes per resident on average. This is in part due to these residents staying longer in the residence than Cohorts 1 and 3. The larger number of case notes

for Cohort 2 may also indicate they were more likely to interact and participate in the program, and thereby have more case notes written about them compared to Cohorts 1 and 3. The Evaluation Team have been mindful of the wide disparity within each of the cohorts on the amount of case notes available, as revealed by the standard deviation. The case notes revealed these cohorts created for the purposes of the evaluation were heterogenous groupings. Some participants had more or less engagement with the program, or less was written about them, irrespective of when they joined or left RRP.

Case notes are inputted by RRP staff who decide what is an event worth recording. The RRP staff consequently dictate to some degree what interactions warrant recording and presupposes no interaction is inconsequential to understanding the resident's stay. Three of the residents (2 from Cohort 1; 1 from Cohort 2) were outliers as they accounted for 20% of the case note pages analyzed. The Evaluation Team decided not to exclude these residents from the case note analysis because the focus was on gathering rich qualitative data. Removing these outliers would hamper how the program deals with complex clients who interact frequently with program staff. Likewise, reducing the sample of the cohorts (e.g., randomly selecting every 5th case note) would limit the richness of the data on how residents fared over time. The purpose of the case note analysis was to triangulate it with the interviews to find common and peculiar themes, rather than suggest the findings are representative of everyone who experiences RRP.

In terms of the coding, the case notes were categorized through thematic coding and a combination of deductive and inductive coding methods.[24] A team of four evaluators coded the case notes keeping in mind the broad themes related to the evaluation, in other words, deductively to answer the evaluation questions (see Appendix G: Case Note Checklist). The abundance of text (e.g., case notes, transcriptions from interviews) did not allow the Evaluation Team to implement a rigorous inter-related reliability process. Nonetheless, the coders met frequently to discuss peculiar and salient themes across both case notes and resident interviews. Additionally, the evaluators coded the case notes inductively, or "bottom up," when the case notes revealed challenges for residents and RRP staff in achieving outcomes.

The evaluators held meetings and reviewed their deductive and inductive coding. The most prevalent themes that emerged from the case note review are presented in the process and monitoring sections of this evaluation. Where possible the evaluators corroborated the themes found in the case notes with those from the one-to-one interviews with residents. In doing so, the Evaluation Team validated the themes unearthed across the two qualitative methods.

2.4. Ethical Considerations

Research and evaluation activities conducted by the JHSO Centre of Research & Policy must comply with the Ethical Guideline for Research Practices. In accordance with this guideline, all research and evaluation activities must receive approval from the JHSO's Research Ethics Board (REB). The REB is an arm's length academic panel established by JHSO adhering to the principles and articles outlined in the Tri Council Policy Statement (TCPS-2), Ethical Conduct for Research Involving Humans (December 2010). The TCPS-2 core principles include respect for persons,

[24] Braun, Virginia, and Victoria Clarke. "Using thematic analysis in psychology." Qualitative research in psychology 3.2 (2006): 77-101.

concern for welfare, and justice. The REB approved this Evaluation Framework alongside the tools which were used on October 16, 2018.

Once Ontario entered a state of emergency on March of 2020, the Evaluation Team consulted with the REB on further data collection processes. The safety risks for continuing with in-person data collection from residents and staff were significantly increased with COVID-19. All in-person data collection was halted under the consultation from the REB. The Evaluation Team then revised the evaluation plan to collect and interview residents and staff remotely, via phone or Microsoft Teams. Staff at JHS-Thunder Bay continued to interact with residents in-person as dictated by their roles and collect administrative and assessment data. For residents who had consented to the evaluation, this data was then shared with the Evaluation Team. No site visits or data was collected by the Evaluation Team after March 2020 to abide the ethical and safety concerns communicated by the REB.

2.5. Evaluation Limitations

Internal Validity: In the absence of a comparison or control group it was not possible to determine if any observed changes in participants could be attributed to the program. When assessing people at two points in time, there are many factors that might account for any changes measured, with program activities being only one possibility. Over a period of more than a year, participants may improve in certain respects even in the absence of treatment. In addition, given that the Residential Reintegration Program (RRP) has several components (e.g., recreational therapy, life skills programming, client-focused support, social navigation), it is difficult to isolate which aspects of the program can be attributed to the change in outcomes.

As noted earlier, COVID-19 impacted the program and resident's lives substantially. COVID-19's impact on resident outcomes cannot be clarified with certainty, as only a small portion of residents completed the repeated measure assessments which tracked outcomes overtime. Moreover, much of the quantitative instruments (e.g., risk and pre-post assessments) with residents were halted due to the health and safety risks to residents and staff. The impact of an external event as large and looming as COVID-19 cannot be measured or quantitatively expressed on resident outcomes in this evaluation.

The Evaluation Team aimed to minimize these threats through a variety of measures. To reduce concerns with instrumentation, the Evaluation Team did not alter the questions within the tools deployed. The same validated tools were deployed on multiple intervals, with the aim that on-going data collection from various sources would increase triangulation. Although this evaluation report cannot quantify the impact COVID-19 had on resident outcomes, the interviews with residents and staff illuminate the challenges the pandemic brought on the RRP.

External Validity: This concerns whether the observed findings are generalizable to other populations, places, and times. The RRP evaluation was not designed to produce generalizable results for the wider public and homelessness programs at-large. This evaluation took place over the course of 3 years and the total sample consists of 56 individuals. Additionally, the intake into RRP is based on risk and need principles, as opposed to a randomized and representative sample

of the homeless population in the Thunder Bay area. The selection criteria are crucial to the operation of RRP, ensuring the right participants engage in its services. Thus, this evaluation was not designed with external validity in mind.

3. PROCESS AND MONITORING FINDINGS

This section of the report outlines the findings from the Residential Reintegration Program's (RRP) process and monitoring evaluation. RRP's process evaluation consisted of 23 evaluation questions which examined the program's delivery across four areas:

1. The overarching characteristics of residents at RRP;
2. The types and frequency of supports delivered;
3. Program satisfaction amongst residents and stakeholders; and
4. The sustainability of RRP operations.

A complete breakdown of the evaluation questions, tools/instruments, and indicators related to each of these four areas is provided in the Evaluation Matrix in Appendix A. As noted earlier, each of the four areas have been impacted by COVID-19. The Evaluation Team created three cohorts to understand whether COVID-19 altered the profile of residents entering RRP and changed service delivery at RRP. All 56 residents who consented to the evaluation were separated by the timing of their entry and exit into RRP, specifically:

- Cohort 1 includes those residents who moved in and out of RRP before the onset of the pandemic.
- Cohort 2 includes residents who moved into RRP before emergency orders were declared for the pandemic, however, they continued living in RRP during the pandemic.
- Cohort 3 includes residents who moved into RRP after emergency orders were declared and had no experience of RRP prior to the pandemic.

The findings below highlight where differences between the three cohorts were notable. Few differences were found between the characteristics of residents across the three cohorts. Differences in programming were more pronounced as COVID-19 had a profound impact on service delivery. Accompanying these findings are the results of the satisfaction surveys and activities by RRP management to sustain the program. This process section concludes with a brief discussion on the profile of residents and RRP operations.

3.1. Program Participants

The RRP is a 47-unit residential facility, where at times 11 units are in use by parole clients from Correctional Services Canada (CSC). Data from CSC clients are excluded as part of this evaluation. Hence, the Evaluation Team could generally approach 36 residents to participate in the evaluation over the course of two and a half years.

The evaluation aimed to recruit approximately 75 individuals into the evaluation. This section of the report outlines whether the program accurately identified and delivered services to the target population and outlines the demographic characteristics of the participants. While the program had on average 32 beds occupied (see section 3.2. for more details), a total of 56 individuals consented to the evaluation over the data collection period. All but seven evaluation participants were recruited prior to disruption during the COVID-19 pandemic. As a result, the findings outlined throughout this report are based on 56 individuals. It should also be noted that some evaluation participants did not complete all of the data collection instruments and as a result the totals in the data presented below fluctuate.

3.1.1. Target Population

Although RRP does not have specific eligibility requirements, it targets adults (18 years of age or older) who are experiencing or are at risk of experiencing homelessness and have a history of criminal justice involvement. An assessment of clients who were not accepted into RRP is beyond the scope of the current evaluation, as that data was unavailable throughout the two and a half years of data collection.

Despite the absence of formal eligibility requirements, the program does take into consideration individual and circumstantial factors when admitting prospective residents into RRP. A situational consideration would include if a prospective resident's co-accused or someone with whom they have a non-contact/communication order is already living RRP; this by default makes the prospective resident ineligible. For a full list of the requirements please see Appendix S.

Intake data from the individuals who consented to the evaluation indicates that the program was very successful in reaching its' target population. Approximately 47% of residents reported experiencing homelessness in the past 12 months prior to moving into RRP. The residents also had considerable experience with the criminal justice system. Almost 95% had previous involvement in the criminal justice system, more than half (59%) had a history of incarceration as adults or in their youth, and 63% of residents were Bail Verification and Supervision Program (BVSP) clients. The RRP is an intervention that fills the gap in the social safety net where homelessness and the criminal justice system intersect. The program effectively targets this gap, as more than 40% of residents indicated having both been homeless (12 months prior to intake) and having a history of criminal justice involvement. Only eight of the 56 residents who consented to the evaluation reported not having any previous history of homelessness and/or criminal justice involvement.

There were minor differences between the three cohorts regarding their experiences of homelessness and justice-involvement. For example, residents from Cohort 1 had a smaller proportion of individuals who experienced homelessness in the 12 months prior to their intake (41%) versus 58% and 57% in Cohorts 2 and 3 respectively. More of the residents in Cohorts 1 and 2 (66% and 67%, respectively) were part of the BVSP compared to those in Cohort 3 (40%). Due to the small sample sizes, the Evaluation Team cannot say with confidence that these differences between cohorts is meaningful and not due to chance (see Table 6 in Appendix C). In informal conversations the Evaluation Team did hear from RRP staff that more individuals

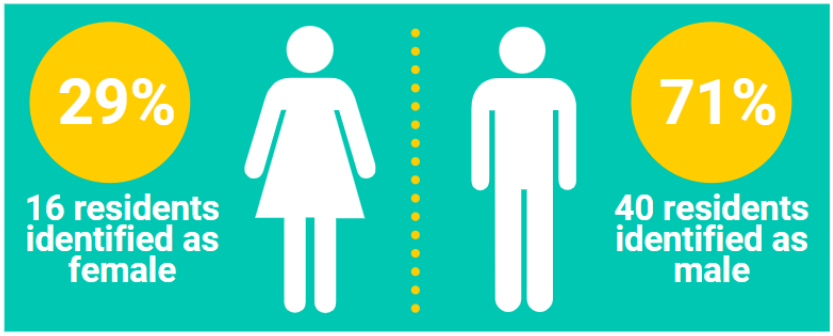
experiencing chronic homelessness were entering RRP after the onset of the pandemic. This may be the case as Cohort 3 included a smaller proportion of BVSP clients than Cohorts 2 and 3. Considering the small sample size and that the pandemic is not over at the time of writing, the evaluation cannot suppose that the target population has leaned more towards those experiencing chronic homelessness, as opposed to those with criminal justice involvement. The RRP has demonstrated the ability to target both homeless and criminal justice populations independently, as well as where those two populations intersect—irrespective of the impacts of COVID-19.

3.1.2. Resident Profile

This section describes the demographic and social characteristics common to residents in RRP. The Evaluation Team performed chi-square analyses to examine whether Cohorts 1, 2, and 3 differ in their demographic and social characteristics. Where statistically significant differences were found it might imply a selection effect, where those who did not experience RRP during COVID-19 were drawn from a different population group than those who stayed in RRP during COVID-19. Nearly all the chi-square analyses found no statistically significant differences between the cohorts, and the results can be seen in Appendix C. Age was the lone factor where the cohorts may be statistically significant different from one another and is addressed further below. This section of the report begins with a description of the overall characteristics among all 56 residents. This is followed by a brief discussion on the statistically significant differences between cohorts on age.

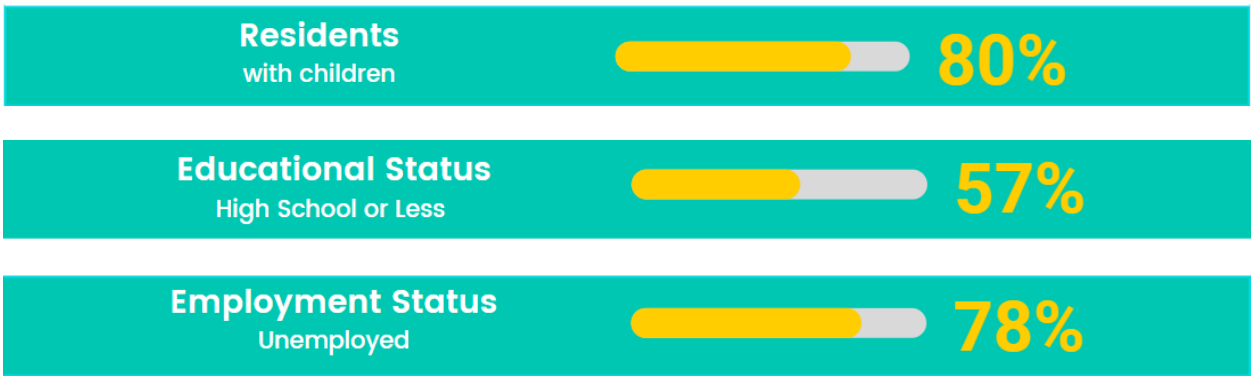
Through the *Client Satisfaction Survey*, residents were asked to share why they started attending the program. Most (n=6) indicated that it was because they were homeless, or they were referred through the BVSP. Others shared that they were referred through external organizations such as the detox centre and Ontario Native Women's Association (ONWA). The resident profile outlined below provides an overview of the complex needs individuals had at the time of entering RRP.

Regarding demographics, residents at RRP were predominately Indigenous, males, and relatively young. The majority of the 56 residents who consented to evaluation (51%) were between the ages of 18-34. Although most residents were relatively young, the program maintained a diverse age range among residents. Over 16% of residents in RRP were aged 55 years old or older. Furthermore, approximately 71% of the 56 residents identified as male with the remaining 29% identifying as female. The majority (61%) of residents also self-selected as Indigenous or First Nations when asked to indicate their ethnicity, with an additional 38% of residents self-reporting as White.



As noted above, a considerable portion of residents had previous experiences of homelessness or criminal justice involvement prior to entering RRP. From the 25 residents who had experienced homelessness in the past year, a quarter (n=6) of them had been homeless three times or more in the past year. The experience of homelessness for RRP residents varied, as one-fifth (n=5) of those who had experienced homelessness in the past year were last homeless 9 months ago or longer. This suggests that a few residents had experienced some housing stability or continuity but that it was short-lived.

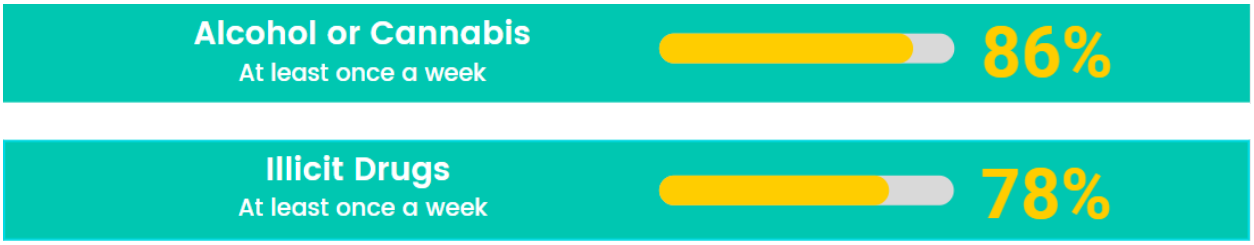
The family and social circumstances of the residents prior to entering RRP is notable. More than two-thirds (67%) of the residents indicated that they were currently single/not in a relationship. However, most (80%) of the residents at RRP had children. The majority (57%) of residents had not completed high school at the time of intake. Accompanying this low educational attainment was the low employment amongst residents. The vast majority (78%) of the 56 residents in the evaluation had also indicated that they were not employed at intake. Only four residents (7%) had full-time employment upon entering the RRP.



Residents at RRP also reported various mental and physical health issues at the time of intake. Approximately one third (34%) of the residents reported having at least one mental health diagnosis, with 16% indicating that they were working with a psychologist. Residents self-reported depression (21%) the most, followed by anxiety (18%) and bipolar disorder (7%).

RRP resident also self-reported a variety of physical health issues. One-third of RRP residents noted a physical health concern at the time of their intake. Approximately 15% of residents reported having diabetes, over 8% reported having asthma and/or lung disease, while 10% reported having a physical disability or mobility issues. A large proportion (45%) of the residents indicated other health issues ranging from heart complications, kidney, cancer, and arthritis among others. Over half (59%) of the residents reported taking some form of medications for their health and/or mental health conditions.

With respect to self-reported behaviour, most residents did not indicate a history of violent behaviour (21%) or physical fights (21%) at intake. Nevertheless, residents reported high rates substance use. Nearly half (42%) of the residents indicated that they have had a problem with alcohol. Of these residents, over a quarter indicated that they currently consume alcohol three to six times a week (11%) or one to two times a week (16%). Illicit drug use among RRP resident was also common, as 57% of residents reporting using crack, cocaine, or heroine at least once a week. Approximately 13% of residents indicated using at least one of these illicit substances daily and an additional 16% used at least one substance weekly.



Over half (56%) of the residents indicated that they had a desire to attend treatment for their substance use in the past. The majority of the residents (60%) indicated at their intake that they were addressing their substance use through treatment, community programs, Alcoholic Anonymous (AA)/Narcotics Anonymous (NA) and/or working with an addiction counsellor.

For the most part, residents across each of the three cohorts did not differ on demographic and social factors. Age is the lone exception, where the chi-square analyses indicated statistically significant differences between the three cohorts. Table 4 below provides a cross-tabulation of cohorts by age. Residents in Cohort 1 were more likely to be younger, whereas a higher proportion of residents in Cohorts 2 and 3 were older than those classified under Cohort 1 (x^2 (10, n=55) =18.658, $p < .05$). For instance, one in five of the residents in Cohort 2 were 55 years or older compared to one in 10 residents from Cohort 1. The Cramer's V for the chi-square in Table 4 is equal to 0.41, indicating a moderate association between cohorts and age.

Table 4: Chi-Square Comparisons Across Cohorts by Age

Age		Cohort			Total
		One	Two	Three	
18-24	#	11	3	0	14
	% within cohort	31.40%	21.40%	0.00%	25.50%
25-34	#	9	4	1	14
	% within cohort	25.70%	28.60%	16.70%	25.50%
35-44	#	5	4	0	9
	% within cohort	14.30%	28.60%	0.00%	16.40%
45-54	#	6	0	3	9
	% within cohort	17.10%	0.00%	50.00%	16.40%
55-64	#	3	2	0	5
	% within cohort	8.60%	14.30%	0.00%	9.10%
65+	#	1	1	2	4
	% within cohort	2.90%	7.10%	33.30%	7.30%
Total	#	35	14	6	55
	% within cohort	100%	100%	100%	100%
x^2 (10, n=55) =18.658, $p < .05$*					

Table 4 suggests the cohorts may have differed from one another by age. Although this association reached the 95% probability threshold and demonstrated a moderate effect, the Evaluation Team is hesitant to suggest that there were clear differences across the three cohorts. The sample size is small, with less than 5 counts in most of the cells—meaning the chi-square is likely inappropriate for ruling out the association is merely by chance. Differences exist between cohorts on age, with the former being younger than the latter. However, the Evaluation Team cannot rule out with certainty whether this is merely due to chance, or if those who stayed in RRP during COVID-19 were significantly older than residents who did not experience RRP during COVID-19. Continuing to track the age of new residents at RRP overtime may reveal if the resident profile at RRP is changing over time.

3.2. Program Services & Supports

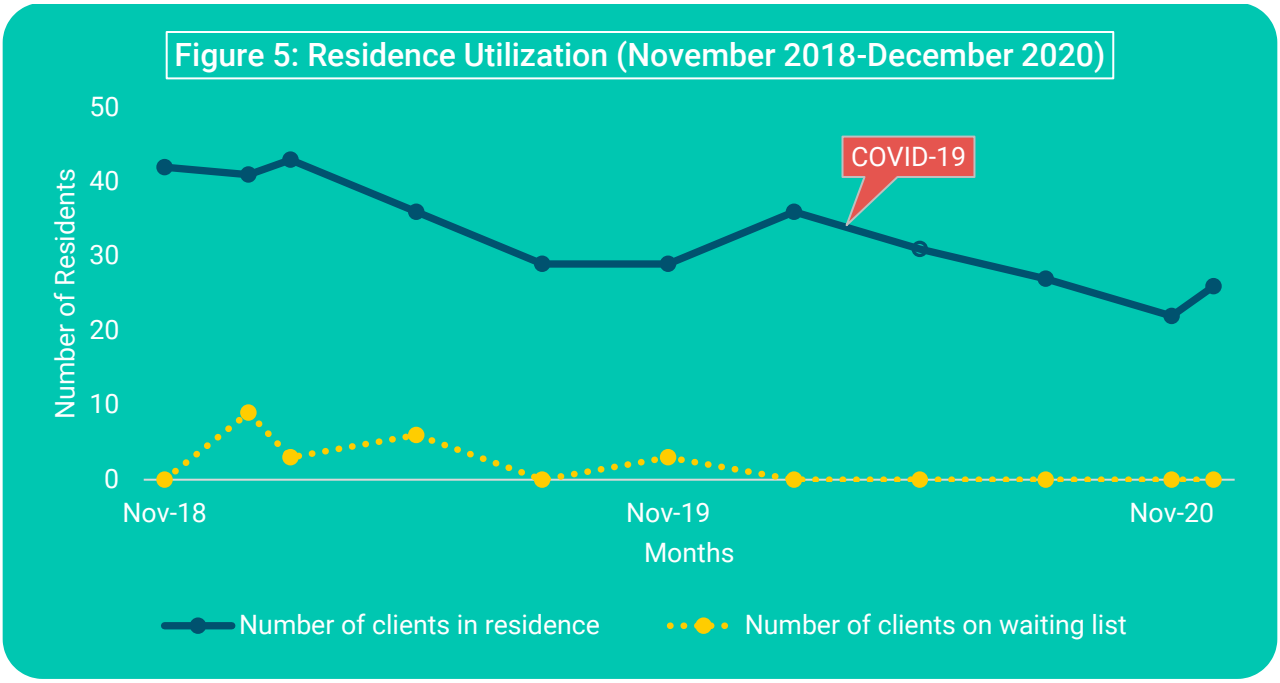
The following section of the report illustrates the findings of the RRP process and monitoring evaluation as it related to program delivery and support services. This section begins with an

overview of RRP's residence utilization, discussion of length and type of supports provided, development of resident goals and action plans, delivery of recreational activities, and the supports provided by the program's Social Navigator. Data for the Program Services & Supports section was collected from 56 program participants and covers the period of November 2018 to December 2020 (with some sections having their data updated in July 2021).

3.2.1. Residence Utilization

RRP had on average 32 beds occupied between November 2018 to December 2020. Data on residence utilization was collected by staff through a standardized form. Between November 2018 and October 2019, the program averaged approximately 33 residents, with an average of one individual on the waiting list to join the program (see Figure 5). RRP fluctuated between 30 to 40 residents between November 2018 to April 2019. In the subsequent months, the number of residents stabilized and remained relatively consistent (between 30 to 35) for the remainder of the data collection period. From November 2018 to October 2019, the number of individuals on the waiting list to join RRP was generally low, with the exception of weeks which had 6 to 9 individuals on the waiting list.

Between November 2019 to December 2020, the average number of residents dropped compared to the previous period to an average of 29 residents (see Figure 5). Between November 2019 to March 2020, the number of residents remained similar to the previous period (30 to 35), however, starting April 2020, the program experienced a slight decrease in the number of residents and averaged between 20 to 30 residents. This decrease was largely as a result of the COVID-19 pandemic. During this time the program limited recruitment, implemented health and safety measures, and other services became available in the community for individuals (see section 5.2. for further discussions on the impact of COVID-19 on RRP).



The evaluation also collected data on the number of serious incidences that occurred between November 2018 to December 2020. During this period there was only one serious occurrence reported.

Of those who completed the *Client Satisfaction Survey,* all residents expressed that they had a positive experience with both the intake process and with moving into the residence when they entered the program, as all rated their experience to be either positive or neutral.

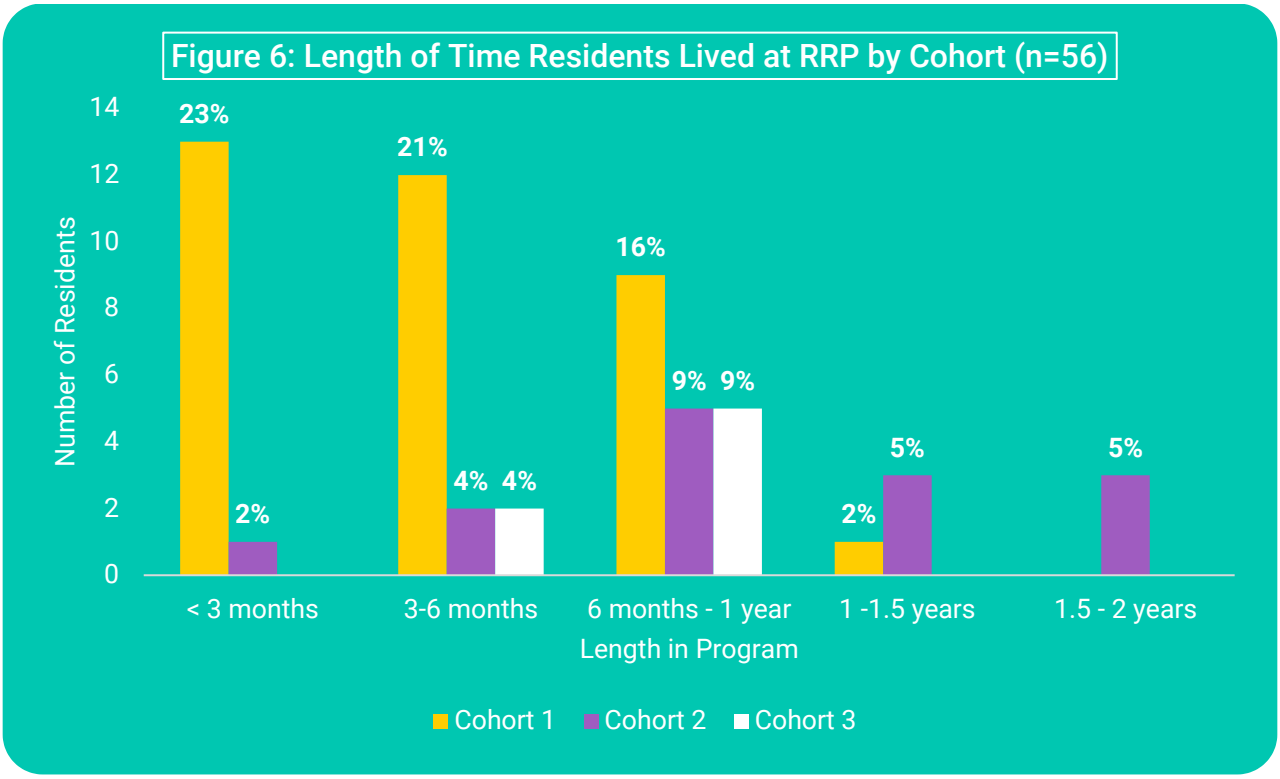
Residence utilization experienced a gradual reduction throughout the data collection period. In 2019, the program averaged 33 residents, however, the pandemic caused the program to slow intake to comply with public health measures. Despite the pandemic, the program was able to maintain an average of 29 residents throughout 2020.

3.2.2. Length of Service & Types of Supports

The RRP provides residents with wraparound services using a client-centred approach. Residents are offered a wide range of programs and services ranging from referrals to community and social services, recreational therapy, and post-program social navigation. Services offered by the recreational therapy and social navigator components of the program are covered in sections 3.2.4 and 3.2.5 of the report. This section of the report provides an overview of the length of stay for residents in the program and the types of services and supports they were offered.

Figure 6 below shows that the length of stay for residents ranged between three months or less to two or more years. About 54% of residents stayed at the RRP for six months or less, while

almost half (46%) stayed for six months to two years. There was also some variation between the cohorts in regard to time in the residence. Time spent in the residence for Cohort 1 appeared to be more dispersed with 71% staying for less than six months and 29% staying for more than six months. In Cohorts 2 and 3, the vast majority (79% and 71% respectively) of residents stayed in the residence for longer than six months.



Residents at RRP who consented to the evaluation engaged in the program for an average of seven months. Males stayed nearly a month longer than females. There was very little difference in terms of length of stay at the RRP between those who had experienced homelessness and those with a history of past incarceration. However, Indigenous residents stayed in RRP for an average of two months longer than non-Indigenous residents. Individuals in Cohort 2 stayed in the program for significantly longer on average (over a year), compared to Cohort 1 (about five months) and Cohort 3 (about eight months).

Residents that stayed at RRP for more than a year were nearly all males and identified as Indigenous or First Nations. Additionally, all but one were BVSP clients, and all but two reported living in an apartment or house prior to joining RRP. This may suggest that their criminal justice matter may have led to their housing precarity. For instance, these residents may be living with the victim or co-accused, and a bail order may not allow them to return to their home until their criminal justice matter is resolved. There are a variety of reasons why these individuals may have stayed longer that cannot be answered through this evaluation. Other examples may include complex criminal justice matters (e.g., multiple charges, domestic violence, etc.), delays in court procedures due to COVID-19, and individuals completing the BVSP yet losing their housing in the

community. The complexities of these residents underscore the need to better understand how the BVSP interacts with residents in the program which will be discussed further in the challenges section (section 5.2) of this report.

In addition to housing, residents at the RRP were provided a number of supports and referrals to various social and community services. The RRP offers breakfast to all residents while also working closely with local foodbanks to provide food for the cupboards that residents can use to make meals. The findings show that participants relied heavily on foodbanks; only one resident on one week did not access the foodbank. Every other week the foodbanks were used by all residents participating in the evaluation.

Residents accessed clothing services 162 times over the course of the program. Residents also utilized the resources and support that was available to them; over a quarter (26%) of the residents were connected to Ontario Works (OW) or Ontario Disability Support Program (ODSP) for income maintenance support. There was also a total of 178 referrals to counselling. It is important to note that the numbers listed here were counted per week and do not reflect the unique number of residents. For example, 178 referrals to counselling does not mean that 178 residents were connected, as it could be the same resident connected on different weeks.

Overall, the length of stay at the RRP by residents ranged drastically depending on need and circumstances. On average residents stayed at the RRP for approximately seven months, with males and Indigenous individuals averaging longer stays. Unsurprisingly, residents in Cohorts 2 and 3 stayed at the RRP for significantly longer than those in Cohort 1.

3.2.3. Resident Goals

One of the key features of the RRP is the individualized case-management approach of the program. As a part of this approach, RRP aims to develop a Resident Action Plan (RAP) for all residents within the first two weeks in the residence. RAPs are co-developed between staff and residents, where they set out the resident's goals and planned activities while in the program. For each RAP, residents identify three goals that they would like to achieve and also the resources that they will require.

Overall, 46 of the 56 evaluation participants completed a RAP and a total of 116 goals were set by the 46 individuals. An analysis of the goals set out by each resident reveals that goals varied and were unique to each individuals' circumstances. Despite the unique quality of creating individualized goals, there were common themes across the goals. The Evaluation Team coded each of the identified goals into broad categories including education, employment, mental health and addiction, physical health, administration, family, and cultural.

Of the 116 goals set out by the residents involved in the evaluation, over 50% related to education (18%), mental health and addiction (17%) and/or employment (16%). Examples of these goals included completing school/GED, looking for work or attending AA/NA meetings to work on sobriety. Residents also created goals related to administrative issues (13%), such as getting

assistance with OW/ODSP applications or obtaining identification cards, health (9%) focusing on exercise or physical activity and securing housing (10%).

There were some differences between the three cohorts in regards to the RAP goals. A total of 71% of all RAP goals were made by residents in Cohort 1, with 27% by Cohort 2 and only 3% for Cohort 3. Employment and education accounted for 41% of all goals for residents in Cohort 1, however, in Cohort 2 only 19% of goals were related to employment or education. Conversely, mental health and addiction related goals accounted for 13% of the total goals for Cohort 1 residents, yet, 29% of goals for Cohort 2 related to mental health and addiction. The numbers of goals and in other categories and in Cohort 3 were too small to draw any meaningful conclusions.

There were also some differences between ages, gender, and ethnicity. Table 5 below shows the most cited themes by residents when developing their RAP goals. Youth between the ages of 18 to 29 years of age, particularly those not in employment or education/training (NEET) are a priority group for LPRF (for a discussion on priority groups, see section 4.6.1.). The Evaluation Team analyzed this specific priority group to assess the goals and any similarities or differences between goals within this group by gender and ethnicity. Youth (18-29 & NEET) were mostly male (n=13) and Indigenous (n=13). The most common goals cited by youth were education and employment, followed closely by administration and mental health and addiction. Of those that had administration goals, all were Indigenous, and specified that they were hoping to obtain identification cards.

Moreover, when looking at all age groups by gender, male residents were more likely to set goals for education, employment, mental health and addiction, and physical health. Female residents, on the other hand, focused goal setting towards mental health and addiction, education, administration, and employment. In terms of ethnicity, residents who identified as Indigenous or First Nations were looking to set goals for education, administration, employment, and mental health and addiction. Non-indigenous residents had similar goals; however, they did not have goals for administration.

Table 5: Most Cited Themes in RAP Goals by Residents (n=116)

NEET	Gender		Ethnicity	
Age Group: 18-29 (n=17)	Male (n=33)	Female (n=12)	Indigenous or First Nations (n=29)	Non-Indigenous (n=16)
• Education (11) • Employment (9) • Administration (8) • Mental Health & Addiction (7)	• Education (15) • Employment (14) • Mental Health & Addiction (14) • Physical Health (13)	• Mental Health & Addiction (6) • Education (6) • Administration (5) • Employment (5)	• Education (15) • Administration (15) • Employment (11) • Mental Health & Addiction (10)	• Mental Health & Addiction (10) • Employment (8) • Education (6)

An overarching theme found in the residents' case notes was their experiences with mental health and addiction: whether they were receiving help for it or not. For residents who did report receiving support for their mental health and addiction, many asked RRP staff for help to connect them and refer them to services, such as counselling, addiction/treatment centres, victim services, and grief supports. Most often, residents asked staff to help them seek out supports to aid them in working towards sobriety and overcoming their addictions. Many residents had a very optimistic and positive attitude towards attending addiction services:

"…looks forward to this programming as [they] can connect with others who are struggling, and both give and receive support for her addiction struggles."

- Resident, Cohort 2, Case Notes

For those who were not accessing supports for their mental health and addiction, staff made efforts to directly provide these individuals with support, some staff even encouraged residents to lean on them when they needed help. One resident declined the offer to be referred to counselling because they felt: *"more comfortable speaking to staff."* Staff also played a crucial role in helping residents develop healthy coping mechanisms to deal with negative emotions such as going through worksheets, breathing exercises, and helping talk residents down when their emotions are heightened.

The program also tracked resident progress towards goals through the *Client Status Survey*. These surveys were designed to be completed monthly during meetings with Case Managers and collected information regarding resident needs and experience in the program. Over the course of the data collection period there were a total of 88 surveys completed by 27 residents, with only 17 residents completing the survey more than once. Although the *Client Status Survey* was intended to be completed each month, residents tended to complete their first and second follow-ups at different points. This flexibility was necessary for staff to offer residents, as the data would likely not have been collected otherwise. Many of the residents can be characterized as transient and difficult to follow-up with at regimented times. Providing this flexibility to residents complicated the data analysis, as four residents completed their first *Client Status Survey* five months after moving into RRP.

It would be unintuitive to include the responses of residents who completed the survey in their first month of moving into RRP with residents whose first assessment was taken five months after having moved in. Consequently, the surveys were grouped into two categories for the analysis:

- Group 1: Includes the first *Client Status Surveys* conducted within one to three months of moving into the residence.
- Group 2: Includes residents from group 1 who also had a second *Client Status Survey* conducted within three to six months of moving into the residence.

Analysing the quantitative measures through these groupings allowed the Evaluation Team to account for the length of stay—a crude measure of dosage—when assessing total and follow-up scores. The upshot of controlling for the length of stay is that there are far fewer *Client Status Surveys* in the sample to analyse. In total, there are 21 residents who completed their first survey within one to three months of moving into RRP, and 14 who had a second survey completed within three to six months of moving into RRP. This sample size was too small to compare scores meaningfully across cohorts, and therefore overall results are presented below.

The *Client Status Survey* asked residents to rate their current progress towards achieving their goal as specified in their Resident Action Plan (RAP), on a scale of 0% to 100%. After being asked to rate the current progress towards their goals, residents were asked to elaborate on what is helping, what is getting in the way, and what could be done to improve their experience. The 21 residents who completed their survey within their first three months of moving into RRP had an average score of 60%. Nearly half of the respondents selected 50% (n=9) in response to this question. Since the 50% acted as the middle response, similar to a "neither agree nor disagree" in a Likert scale, it is possible that many respondents had not had enough time in the program to work on their RAP goals and therefore selected 50% as a neutral assessment of their progress.

Two respondents noted in the open-ended portion of the survey "I just need to wait for my main goals to happen," and "I'm ok right now but I think later I will know." It is not possible to discern whether all the respondents truly meant they were halfway through their goals within the first month to three months of moving into RRP or simply selecting a neutral response.

Although many residents selected 50%, seven of the 21 rated their progress highly (between 70% to 100%). A few residents noted JHS-Thunder Bay staff and their job amidst a wider array of supports as helping them attain their goals, for example:

"The staff here at the John Howard, some clients, my employer, my counsellor, AA, my sponsor."

-Resident, Client Status Survey

Amongst the 21 residents who completed a *Client Status Survey* within their first three months of moving into RRP, there were 14 who also had a second survey administered within three to six months following their RRP start date. Six of these 14 residents indicated higher scores in their follow-up assessment compared to their first, while five recorded negative scores, and three were unchanged. Three of the six respondents reported a 10% increase from their initial assessment, and one resident reported a 40% increase in their progress in achieving their RAP goals. These respondents mentioned JHS-Thunder Bay staff, the RRP, sticking to a routine, or keeping the end in mind as helpful in making progress towards their goal.

The reasons were diverse for those who scored lower or had not reported a change in their follow-up compared to their initial survey. Residents cited a variety of reasons for not making progress on their goals, including missing appointments for services, family issues taking precedence, or declines in their physical health. Suggestions to improve their progress were also

distinct, with one recommending extending the curfew in the residence, support for unpaid wages from an employer, and access to Wi-Fi.

The Evaluation Team could not fairly examine all the numerical ratings for the 88 *Client Status Surveys*, as initial and follow-up surveys were administered at different times. Nonetheless, the qualitative component of the surveys, such as what was helping, getting in the way, or could be done to improve access to their progress did not need the same controls to the length of stay. General themes were coded amongst the surveys to relay frequent supports, challenges, and suggestion cited by residents. Generally, those who indicated that their progress towards their goals improved reported that working on their mental and physical health was helpful. Residents accomplished this through engaging in activities such as yoga, Alcoholics Anonymous (AA), nature walks, and healing circles.

Residents whose progress towards their goals did not change reported that having access to culturally appropriate programming was helpful. For example, residents found it helpful to have pipe ceremonies and interactions with elders as this helped them progress in their personal needs. Although they did not make progress towards meeting their goals, many still reported that they found the support from JHS staff helpful. Overall support for resident mental and physical needs, having access to culturally appropriate resources, and attending to their physical health issues were also helpful. Residents whose progress towards goals stayed the same often reported that issues related to money were getting in the way of improving. Additionally, numerous residents reported issues with curfew. Some residents discussed issues related to sobriety, specifically staying away from others who were not sober.

Residents shared some suggestions on how their experience could be improved, which includes but is not limited to the following: connecting with professionals who would help them find a job, self-healing through participating ceremonies and methods not offered through JHS, having increased access to Wi-Fi, more food supports, having access to more job opportunities/income and more affordable accommodations, gaining more information on jobs and school would be helpful, and gaining access to different areas of work and programs.

3.2.4. Recreational Therapist

As noted throughout this report, many residents at the RRP have been involved with the criminal justice system, and often lack access to and engagement in positive pro-social activities. Recreational opportunities for individuals experiencing homelessness have demonstrated improving quality of life and coping skills. The use of recreational therapy can elevate emotional, physical, and social elements of life and improve the development of community and social skills, empowerment, coping, and leisure skills. A key component of the RRP is the Recreational Therapy program, which began in April 2018. These sessions were open to all RRP residents, JHS-Thunder Bay clients and the Thunder Bay community.

Boredom and disengagement are barriers to successful reintegration among residents at the RRP. As part of funding provided by the Local Poverty Reduction Funding, a Recreational Therapy component was introduced to the RRP. The objectives of the Recreational Therapy component

include identifying and/or creating recreational activities and encouraging clients to pursue new opportunities.

The recreational therapy activities were grouped into five distinct categories:

- Socialization (e.g., soup & tech, bingo),
- Health (e.g., yoga, hiking),
- Cultural (e.g., morning smudge, storytelling)
- Recreation (e.g., movie nights, trips in the community), and
- Life Skills (e.g., build your own bike, self-help workshops).

Table 6 outlines the number of sessions and attendance by activity category both in 2019 and 2020. The types of activities and number of attendees differed significantly between the two years, which is likely a direct result of the COVID-19 pandemic. In 2019, socialization, cultural, and life skills activities recorded the highest number of sessions and attendees, while recreation activities had the fewest. In 2020, life skills, recreation, and cultural activities recorded the highest number of sessions and attendees. On average, across all categories, there were substantially fewer residents attending recreational therapy programs in 2020 compared to 2019.

Table 6: Recreational Therapy Programs & Attendance (Jan 2019-Dec 2020)

Category	Total # of Programs Sessions		Total Attendance		Average Attendance per Session	
	2019	2020	2019	2020	2019	2020
Socialization	29	26	160	22	15	2
Health	26	27	92	13	9	1
Cultural	37	28	149	32	15	3
Recreation	14	39	52	33	5	3
Life Skills	35	31	141	37	13	3
Total	292		731		7	

In addition to these sessions, residents also had the opportunity to use tablets after a local organization donated them to JHS-Thunder Bay in August 2019. The Recreational Therapist was responsible for signing out tablets to residents and the attendance records demonstrated that these were very popular, as 2-6 residents were signing out the tablets each day.

Through interviews with residents and an analysis of case notes, residents shared that they enjoyed participating in the various types of recreational activities and programming. The types of activities that were discussed most often were day trips, such as trips to the museum, going on hikes and/or the local waterfalls. However, many discussed the challenges in attending outdoor activities such as hikes due to physical barriers and health issues. Additionally, many non-physical activities such as movie nights, cooking, and arts and crafts were discussed as residents enjoyed the social atmosphere that these activities provided. One resident commented that the activities that involve food are always popular among residents.

Due to the COVID-19 pandemic, the Recreational Therapist's role was altered, as they were limited in how they could deliver programming. Instead of in-person group programming, the Recreational Therapist provided programming online through *Zoom* and *Facebook Live* when possible or delivered programming one-on-one. This was challenging for both the Recreational Therapist and the residents since the group programming component was an enjoyable and impactful experience for residents. The shift in programming is likely attributable to the lower attendance numbers in 2020. For more details on how COVID-19 impacted the program, see the *Impact of COVID-19* section (section 5.1.).

Residents shared that when activities shifted from in-person programming to online, it was difficult for some residents due to issues with accessing and using technology, as well as the lack of social engagement between residents. When programming was offered in-person during the pandemic, only a limited number of residents were able to participate, making it difficult to schedule it and include residents to participate.

Program staff recorded the activities that each resident participated in including a description of the activity, the number of hours spent engaging in the activity, and any additional comments regarding the resident's participation.

Out of the 38 residents whose data was collected, residents participated in a total of 330 activities which occurred between December 2018 to December 2020. Upon further analysis, two residents from Cohort 2 were responsible for one-third of the programming hours. To give a more accurate depiction of the average activities and time spent across residents and cohorts, the Evaluation Team removed these outliers who spent about 70 and 100 hours, respectively (67 hours in 43 activities; 98.5 hours in 71 activities). As such, the data presented in Table 7 below reports on 36 residents.

As demonstrated in Table 7 below, on average, residents (excluding the outliers) engaged in 6 activities and spent 8.8 hours engaging in activities. The total number of activities which one resident participated in throughout the time period ranged from 1 to 22, while the total number of hours each resident spent engaging in activities ranged from 1 to 31 hours. The data was also broken down based on the three cohorts of residents depending on the point-in-time that they were involved in the program. Overall, individuals in Cohort 1 spent the most time engaging in activities compared to the other cohorts.

Table 7: Total Activities & Dosage (Dec 2018-Dec 2020)

	# of activities	Mean # of activities	# of hours	Mean # of hours
Cohort 1 (n=30)	174	5.8	269.5	9.0
Cohort 2 (n=5)	39	7.8	47	9.4
Cohort 3 (n=1)	3	3	1.5	1.5
Total (n=36)	**216**	**6.0**	**318**	**8.8**

Through the *Client Satisfaction Survey*, residents were asked to rate the usefulness of the recreational programming at RRP. Residents (n=9) who had completed the survey rated the programming positively, with most rating it 'Useful' (n=6), two rating it 'Very useful,' and only one selecting 'Neutral.' Similarly, when asked how satisfied residents were with the life skills program,

most respondents rated the life skills training component as 'Useful' (n=7); however, two individuals indicated that they found this component of the program 'Not too useful.'

Additionally, staff also shared through interviews the impact that the Recreational Therapy component has had on residents, particularly the connections and friendships that were developed between residents during in-person programming.

"The greatest thing for me to watch during programming (in-person anyway) is the friendships that develop and the teamwork skills that develop, totally inadvertently,…I remember one hike that we went on in the snow, there was some difficult places to navigate on that trail and people that wouldn't even normally converse with each other in the hallways were helping each other over these obstacles or breaking sticks so that everyone had a walking stick and turning around to make sure no [person] was left behind…that social aspect has been really cool for me to watch."

- Staff, Interview

Despite the decreased number of individuals accessing services throughout 2020 due to the pandemic, the RRP has been successful in delivering programming and activities to a wide range of individuals given the circumstances. This demonstrates that the Recreational Therapy component of the program has been valuable and impactful to the residents.

3.2.5. Social Navigator

Another key component of RRP are the activities done by the Social Navigator. The Social Navigator provides case management and navigation services designated to assist residents in obtaining stability in their lives. The Social Navigator is the point of contact for coordinating and liaising with community services and landlords to assist in the transition for residents to move to the community. The Social Navigator works closely with residents to determine an appropriate time to transition to housing in the community and identify and secure appropriate long-term housing and community services (e.g., completing paperwork and lease arrangements). Once individuals have moved out of RRP into the community, the Social Navigator continues to provide case management services, including regular and ongoing follow-up supports for up to 12 months to facilitate a successful transition and long-term housing stability. The activities of the Social Navigator at JHS-Thunder Bay are centred on obtaining three goals for residents:

1. To find and secure housing in the community for residents to move into;
2. To help residents navigate the services available from community partners; and
3. To provide ongoing support once residents leave the program.

An analysis of the Social Navigator Tracking forms and case notes revealed that the Social Navigator provided a variety of supports to residents. The Social Navigator worked closely to secure housing in the community for 31 of the 56 residents who consented to the evaluation. The Social Navigator worked with all of the residents, unfortunately, only those who consented to the evaluation could have their data shared with the Evaluation Team and presented here. From these

31 residents, 18 were from Cohort 1, an additional 12 residents were from Cohort 2, and one resident was from Cohort 3.

An analysis of the case notes revealed that residents were in contact with the Social Navigator, on average, for eight and a half months. Residents within Cohort 1 were in contact with the Social Navigator significantly more compared to residents in Cohorts 2 and 3. As residents in Cohorts 2 and 3 lived in RRP during COVID-19, it is likely that they had difficulty transitioning to housing in the community during the pandemic. Overall, the Social Navigator was successful in reaching residents once they transitioned into the community. The Social Navigator attempted to reach out to residents 204 times over the course of the evaluation and was successful 83% (169) of the time in connecting with residents in the community. Table 8 provides a summary of the outputs and housing outcomes attributable to the Social Navigator — more detailed housing outcomes are provided in section 4.1. of the report.

Table 8: Social Navigator Post-Program Contact & Supports				
	Cohort 1	Cohort 2	Cohort 3	Total
Social Navigator Contacts (n=29)				
Contact Attempts	159	37	8	204
Successful Contacts	130	22	6	169
Social Navigator Supports (n=31)				
Left JHS	16	7	1	24
Housed in the Community	12	2	1	16
Rehoused in Community	5	1	0	6

The Social Navigator forms indicated that 24 residents had left the RRP and worked closely with the Social Navigator to secure housing in the community. From these 24 residents, 16 were housed. Six of the 16 former residents had to be re-housed after initially obtaining housing. Two of the 16 individuals were re-housed twice, meaning the Social Navigator secured housing for them in the community two different times. The Social Navigator was successful in maintaining contact with 26 residents after they had completed the RRP. Table 9 below details residents contact with the Social Navigator at various frequencies. The Social Navigator forms indicated that most former residents had monthly or weekly contact with the Social Navigator, and this was consistent across Cohorts 1 and 2. In terms of the method of contact, in-person contact was the most common form of contact.

Table 9: Social Navigator Contact with Clients				
	Cohort 1	Cohort 2	Cohort 3	Total
Frequency of Contact				
Weekly	2	3	0	5

Bi-weekly	1	2	0	3
Monthly	5	2	0	7
Intermittent	2	0	0	2
No Contact	6	2	1	9
Other	2	2	0	4
Method of Contact				
Phone & In-person	2	0	0	2
Phone only	4	0	0	4
In-person only	7	6	1	14
Social Media	2	1	0	3
Other	3	0	0	3

Cohort 1 demonstrated a more diverse range of contacts compared to Cohorts 2 and 3. This may be attributable to the change in the Social Navigator's role following the pandemic where they were focused on providing public health supports (e.g., providing masks, hand sanitizer, naloxone kits) to former residents. Unfortunately, these were not recorded as official contacts in Tables 8 and 9, as the contacts noted there relate exclusively to housing. Such miscellaneous or unanticipated contacts were not captured in the *Social Navigator Tracking* form. During the pandemic, there was a greater need for the Social Navigator to ensure the safety of former residents in the community as opposed to focusing purely on housing needs.

"What I do during some of the days is I essentially do an outreach component… I'll drive around and look for our clientele. Due to the opioid overdoses and a lot of the situations, many clients are hospitalized so there's a couple of them that are regularly hospitalized that I'm actually the contact at the hospital for them so the hospital will let me know that they're there. If they're there during that time, I'm able to access them with a phone."

- Social Navigator, Interviews

As evident from the results in Table 9 above, the activities of the Social Navigator began to slow down during the pandemic, particularly, in the start of the second half of 2020. Discussions with RRP management and staff indicated that the Social Navigator began to support the community during the COVID-19 outbreak. Staff reported that the Social Navigator became more involved in supporting individuals not part of the RRP but who were experiencing or at risk of homelessness. Supports, referrals, and social navigation was offered to the individuals outside of JHS-Thunder Bay to ensure that those who needed supports were referred to and had access to appropriate services in the community.

An analysis of case notes revealed that many residents felt that the Social Navigator was helpful in supporting them with completing social housing applications, legal aid applications, and obtaining and completing other relevant forms. The Social Navigator went above and beyond to connect residents with suitable housing for residents' unique situations, with many residents expressing their gratitude towards the Social Navigator.

"Without [the Social Navigator] I would never be able to move here."

- Resident, Cohort 2, Interviews

The Social Navigator continued to provide access to supports and services to residents after they moved out, particularly food support as food security was a considerable challenge for residents. Another frequent request that the Social Navigator was asked to assist with was helping residents obtain identification (e.g., health card, status card, Birth Certificate). Additionally, the Social Navigator also supported residents who had moved out with scheduling and attending appointments, picking up prescriptions, navigating landlord and rental issues (e.g., bed bugs, replacing furniture, lease changes, missed rental payments), transportation, support in leaving abusive relationships, attending court, clothing support, and connecting them with addiction treatment and services.

The Social Navigator also provided support to residents for a litany of personal matters, such as preparing for the birth of a child (e.g., pre-natal appointments, finding clothing and supplies, finding the appropriate housing), supporting residents in toxic and violent relationships, gaining custody of children, and assistance in navigating the legal system. In one unique situation, the Social Navigator was able to help a resident with health issues move out of the RRP into their own apartment due to the pandemic, despite their bail conditions requiring them to live at RRP.

Client Satisfaction Surveys were administered to residents who completed the program and left the residence. A total of 10 residents completed the survey. Individuals were asked to rate, out of 10 (0 – not at all helpful to 10 – very much helpful), how helpful the Social Navigator had been in helping them obtain and retain housing in the community. Seven respondents answered the question, producing an average rating 7.71 out of 10. Two respondents selected 10 and one selected nine, providing comments such as:

"Always helping me ALOT (sic)."

- Resident, Client Satisfaction Survey

"[The Social Navigator] helped me with my low-rental housing application and forms. [They] went with me to a meeting with OW housing worker."

- Resident, Client Satisfaction Survey

Residents were also asked to specify the ways the Social Navigator has not been helpful, where only two different reasons were provided. One individual stated that the Social Navigator is always helpful, while the other shared that the Social Navigator's workload was too heavy, impacting their ability help to residents with their needs.

Overall, the Social Navigator was successful in connecting with a variety of residents over the course of the data collection period. The Social Navigator successfully connected with residents a total of 169 times and provided 16 residents with a place to live in the community.

3.3. Program Satisfaction

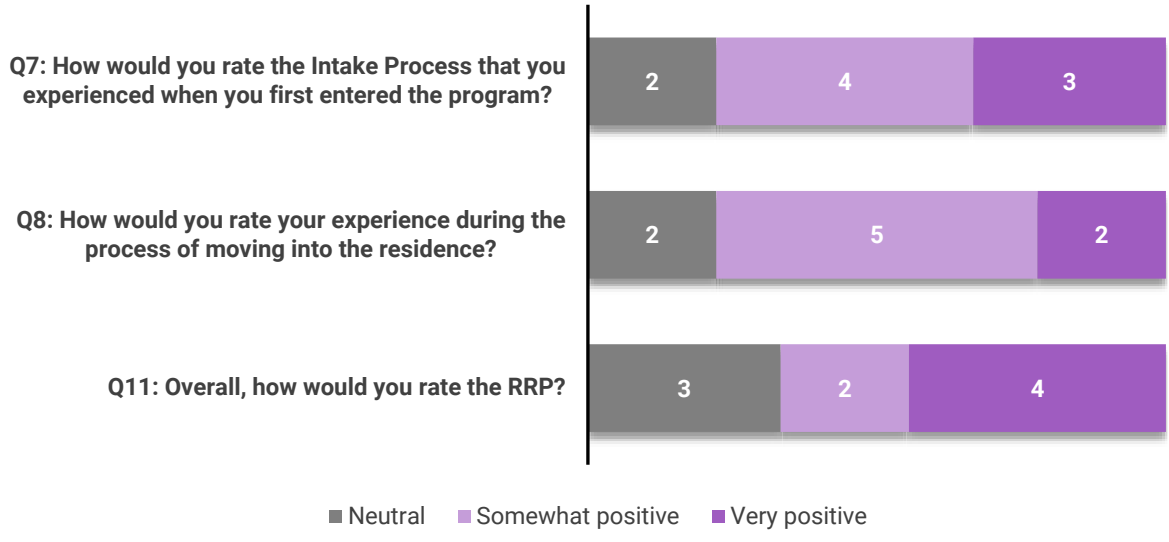
The following section provides an overview of the RRP residents and stakeholders' satisfaction of the program. For further details on the survey results, refer to the *Satisfaction Survey Report* (see Appendix D & E).

3.3.1. Resident Satisfaction

As briefly mentioned in previous sections, the *Client Satisfaction Surveys* were administered to those who completed the program and left the residence. Overall, a total of 10 residents completed the survey between April 2019 and June 2019, with only residents from Cohorts 1 and 2 having completed the survey. Overall, participants were satisfied with various aspects of the program such as the intake and moving process, the positive impact that the program has had on their lives, and the RRP staff.

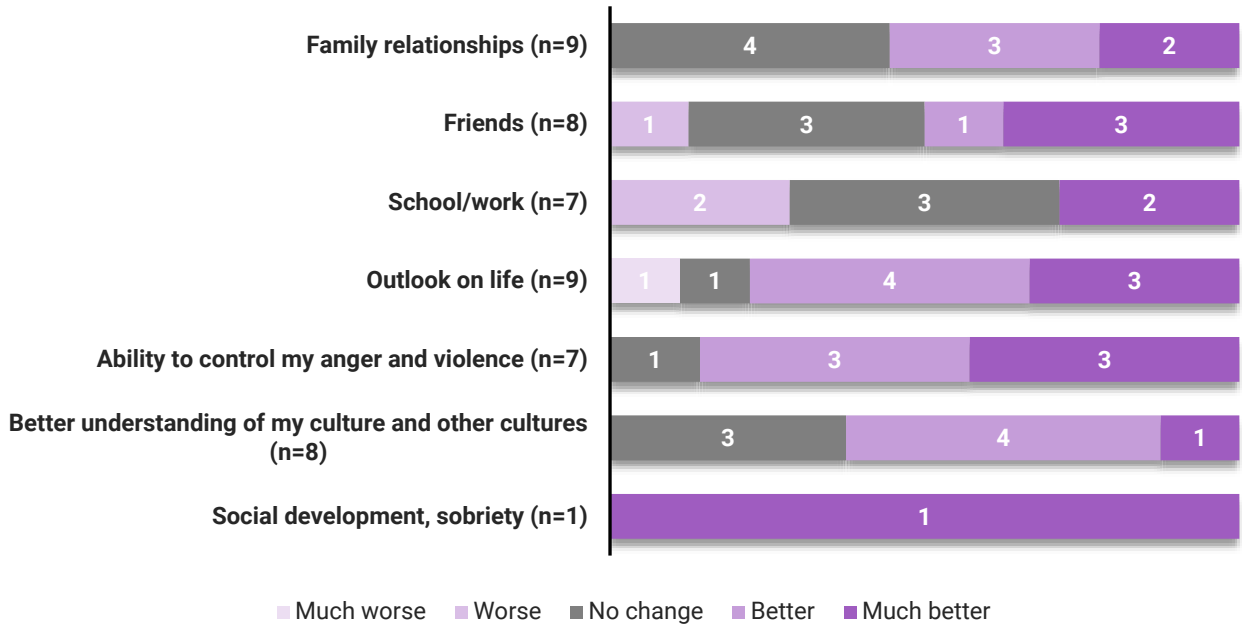
Residents were asked to rate their experience with the intake process when moving into the residence and the program overall. As demonstrated in Figure 7 below, residents had a positive experience with all three components of the program, as most indicated 'Very Positive' or 'Somewhat Positive.'

Figure 7: Residents Satisfaction with Program



Residents were also asked to reflect on their life 6-months prior to entering the RRP and compare it to how their life is after joining and participating in the program. Residents were provided with a list of different aspects which apply to their life and were asked to indicate if these areas have changed. For the most part, individuals indicated that these areas in their life had improved. However, some residents indicated that their school/work and friends had gotten worse. Results are outlined in Figure 8 below.

Figure 8: Life Changes Following the Program

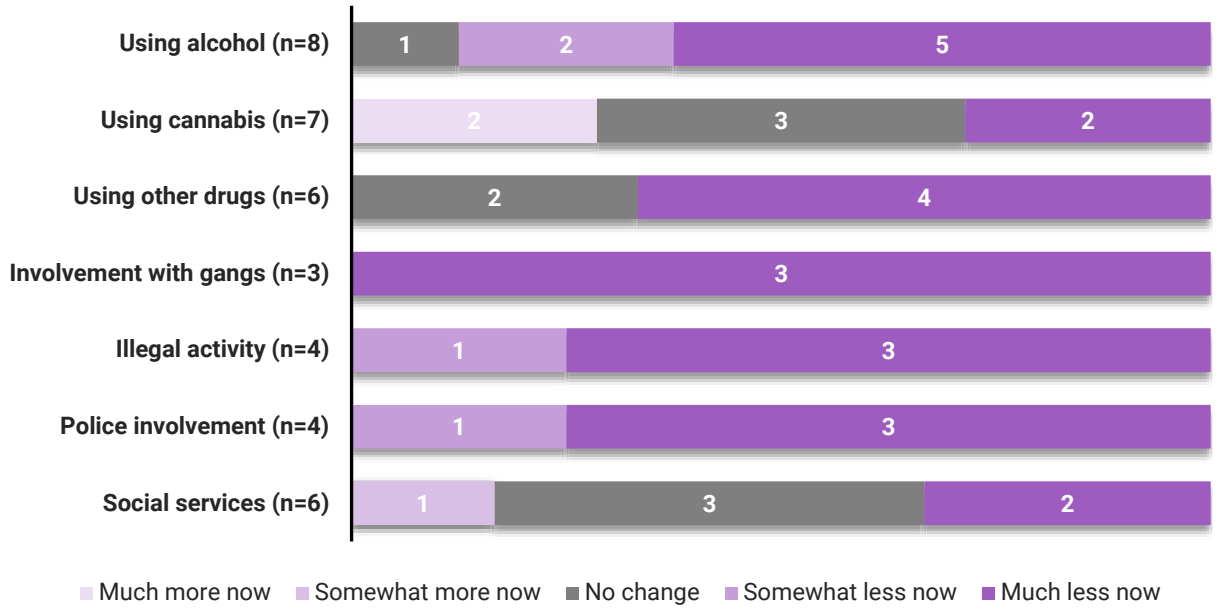


Additionally, residents were asked to reflect on how frequently they were involved with various activities at the present time compared to how frequently they were involved in the same activities before entering RRP. For the most part, individuals indicated that they had become less involved in the activities listed or the activities were not applicable to them.

For those who have shared that they had become less involved in certain activities, five stated they had become less involved in using alcohol, and four indicated that they had become less involved with using other drugs (not including cannabis and alcohol). For those who did state that they had become more involved in certain activities, two respondents indicated that they had been using cannabis more frequently and one indicating that they had been more involved in social services. Results are outlined in further detail in Figure 9 below.

It is important to note that some individuals stated that these activities are not applicable to them. It is possible that, in some cases, individuals may not have felt comfortable disclosing this information and selected this option instead.

Figure 9: Involvement with Activites after RRP



Additionally, all individuals stated that they would recommend this program to someone else due to the help provided from the staff and the positive impact the program has made on their life. Further, residents indicated that the program was most helpful in reducing homelessness, maintaining sobriety, developing life skills, building relationships, and experiencing freedom. As well, residents indicated that the program has helped them in managing their lives and progressing towards achieving their goals. For a more in-depth analysis of the *Client Satisfaction Survey*, see Appendix D.

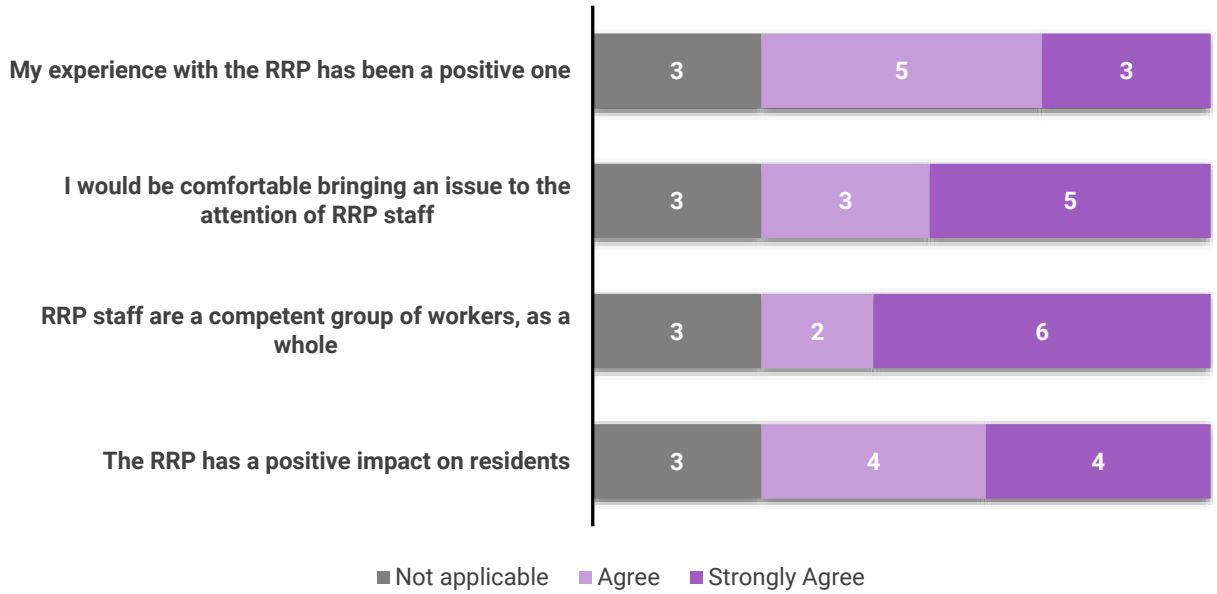
Overall, residents were satisfied with the program. Residents reported that after being involved in the program they had noticed positive changes across various aspects of their life and the program, positively impacting their lives. More specifically, residents noted that the RRP had helped them achieve their goals, reduce homelessness, maintain sobriety, develop life skills, and build relationships.

3.3.2. Stakeholder Satisfaction

Program *Stakeholder Satisfaction Surveys* were administered to external partners of the RRP, including community service agency partners, landlords, police officers and community members. Surveys were administered at two intervals: first in December 2019, and again in May 2021. Overall, a total of 14 stakeholders completed the survey. Throughout the surveys, stakeholders shared that they were satisfied with various aspects of the program including their communication with the program, their involvement with the program, the positive impact the program had on residents, and program staff.

Stakeholders were asked to rate their agreement with a variety of statements related to their experiences with the RRP; all were rated positively. As demonstrated in Figure 10 below, stakeholders agreed that the RRP had been an overall positive experience, feel comfortable communicating with staff, believe the staff are suitable for the job, and believe that the program has had a positive impact on residents.

Figure 10: Stakeholders Satisfaction with Program



Stakeholders were also asked to elaborate on their experience with the RRP, to which five individuals provided a response. Of those who provided feedback, stakeholders shared that the program provided support to hard-to-reach clientele and believe that the program should be expanded to meet the high demand:

"The staff were incredibly supportive and responsive to making certain the men and women were active participants in their healing journey."

- Stakeholder, Stakeholder Satisfaction Survey

"Very good program, just needs to be expanded to meet demand."

- Stakeholder, Stakeholder Satisfaction Survey

All stakeholders shared that they would recommend this program to others, and many believe that the program made a positive difference in the lives of vulnerable clients with unique needs.

Many mentioned that the program is essential for securing and maintaining housing and assisting in navigating housing options, the program makes a positive difference, and the organization focuses on the needs of vulnerable clients with high needs.

"[The] program is making a positive difference for clients."

- Stakeholder, Stakeholder Satisfaction Survey

"I support agencies that are focused on the needs of the most vulnerable client. The John Howard Society of Thunder Bay does just that."

- Stakeholder, Stakeholder Satisfaction Survey

Although most found the referral process to be a success, many stakeholders shared that COVID-19 limited their ability to provide programming and services to RRP residents and their ability to make referrals to the program due to decreased face-to-face interactions.

Most stakeholders shared that the services they were most aware of was the housing supports provided by the Social Navigator, with some even highlighting the housing supports to be the most positive feature of the program. In terms of program challenges, stakeholders mentioned that the program would benefit from additional funding and resources to better address the complex needs of their clients.

The survey results demonstrated that program stakeholders were satisfied with various aspects of the program including their communication with the program, their involvement with the program, the positive impact the program has had on clients, and program staff. All stakeholders shared that they would recommend this program to others, and many believe that the program makes a positive difference in the lives of vulnerable clients with unique needs. For a more in-depth analysis of the *Program Stakeholder Satisfaction Survey*, see Appendix E.

3.4. Fidelity to Client-Centred Approach

The Residential Reintegration Program (RRP) at JHS-Thunder Bay follows a client-centred approach to offer wrap-around supports to residents. As a result, the Evaluation Team developed a checklist to measure the extent to which Case Managers, Recreational Therapists and Social Navigators complied with client-centred best practices.

These checklist measures program fidelity based on *Full compliance*, *Partial compliance,* and *Limited/no compliance*. Best practices include:

- Assisting clients to clarify and articulate their important values, challenges, and strengths.
- Ensuring that clients drive the process of identifying goals that are right for them.
- Prompting clients to determine the best course of action and to take action when ready.
- Directing clients to resources and opportunities in the community based on identified needs and the expressed interests and desires of clients.
- Helping clients understand the advantages and disadvantages of different approaches.
- Making referrals to partner services as appropriate given clients' motivation and timeframe.

The Evaluation Team assessed the fidelity of RRP to the client-centred approach based on the data collected from program staff, residents, stakeholders and other process evaluation tools and measures.

Table 10: Client-Centred Fidelity Checklist

	Full compliance	Partial compliance	Limited/no compliance
1. Assisted clients in clarifying their key values, challenges, and strengths	(✓)	( )	( )
2. Allowed clients to drive the process of identifying goals	(✓)	( )	( )
3. Identified clients' skills and capacities, existing resources, challenges and supports need to reach short and long-term goals.	(✓)	( )	( )
4. Asked motivating questions to prompt clients to determine the best course of action and to take action when ready	(✓)	( )	( )
5. Informed clients of resources and opportunities in the community based on the assessment and expressed interests and desires of the client	(✓)	( )	( )
6. Helped clients understand the pros and cons of different approaches, and supporting them when they decide how best to meet their goals	(✓)	( )	( )
7. Made referrals to services in partnership with clients' motivation and timeline, on the assumption that the client is the expert	(✓)	( )	( )
8. Exercised respect, non-judgmental attitudes, attentive listening, and empathy to establish trust and maintain the dignity of the client	(✓)	( )	( )
9. Used positive reinforcement and encouragement for achievements.	(--)	(--)	(--)

Table 10: Client-Centred Fidelity Checklist			
	Full compliance	Partial compliance	Limited/no compliance
10. Individualized care based on each client's goals and unmet needs.	(✓)	( )	( )
11. Reframed challenges as barriers to goals rather than intrinsic characteristics of individuals	(✓)	( )	( )

Based on an analysis of JHS-Thunder Bay's activities and procedures, the RRP received *Full compliance* in all but one of the fidelity measures. It should be noted, however, that many of the program's procedures and activities were significantly impacted by the COVID-19 pandemic and the health and safety measures put in place by JHS-Thunder Bay.

The program had robust intake and onboarding procedures driven by a client-centred approach. As a result, the program received *Full compliance* for measures related to the following best practices:

- Assisting clients to clarify and articulate their important values, challenges, and strengths.
- Ensuring that clients drive the process of identifying goals that are right for them.
- Prompting clients to determine the best course of action and to take action when ready.

All of the clients involved in the evaluation completed assessments such as the Service Planning Instrument (SPIn) and an in-depth intake process to draw on residents' values, challenges, strengths, and capabilities. This served to inform the goals residents set in their Resident Action Plan (RAP) and the types of programming and supports that would be beneficial to each individual. One of the key features of the RRP is the individualized case-management approach of the program where staff collaborate with residents to develop an individualized RAP. For each RAP, the residents are involved in the process of identifying three goals that they would like to achieve as well as well as any resources or supports that may help them achieve their goals. RAPs are co-created by Case Managers and residents during the first few days/weeks of a resident entering the RRP. Case Managers utilize motivational interviewing techniques to encourage residents to develop goals based on their own needs and strengths.

While developing the RAP, Case Managers also discussed any risk and protective factors and/or challenges that were revealed in the residents SPIn assessment. They worked collaboratively with residents to identify goals and determine any activities and supports to help residents reach both their short-term and long-term goals. Case Managers continued to connect on a frequent basis with residents on how they are coping with their transition to RRP, how they are progressing in achieving their goals, and how they are managing in general. The Case Manager worked with the residents to motivate them and would re-adjust their RAPs if needed. Additionally, residents were able to choose what activities and supports they wanted to engage in to achieve their goals; program staff did not decide for the residents. A total of 46 RAPs were available to the Evaluation Team, where a total of 116 goals were set.

The program also received *Full compliance* for measures related to the following best practices:

- Directing clients to resources and opportunities in the community based on identified needs and the expressed interests and desires of clients.
- Helping clients understand the advantages and disadvantages of different approaches.
- Making referrals to partner services as appropriate given clients' motivation and timeframe.

The RRP offered a wide range of programs and services ranging from referrals to community and social services, recreational therapy, and post-program social navigation. Residents at the RRP were provided with several external supports and referrals to various social and community services including food and clothing support, counselling, and income maintenance support through Ontario Works (OW) and Ontario Disability Support Program (ODSP). Other external services provided programming at the RRP to supplement the programming that was not offered internally. Staff also reported high participation and attendance of residents in internal programming and supports.

Internally, residents accessed clothing services 162 times over the course of the year. Residents also utilized the resources and supports that were available to them; over a quarter (26%) of the residents were connected to OW or ODSP for income maintenance support. RRP staff made referrals to partnering services based on residents' goals and their needs. Staff would only make the referral if the resident was open to accessing the supports and services. Instead of being referred to specific supports, some residents indicated that they felt safer and more comfortable confiding in JHS staff when they encountered a barrier. When a staff suggested making a referral, a resident responded that they feel: *"more comfortable speaking to staff"*. There was also a total of 178 referrals to counselling.

When developing the RAP, residents are given the option to engage in a variety of different recreational therapy activities based on their preferences to best meet their goals. Based on data collected, RRP staff were consistently respectful, empathetic, and compassionate towards the residents. Staff were always open to listen to residents regardless of the topic and were open-minded and non-judgmental towards residents. As a result, RRP staff established trust and rapport with the residents.

Case note data indicates that after the RAP was developed, Case Managers continued to connect on a frequent basis in a therapeutic way to discuss how they are coping with their transition, how they are progressing in achieving their goals, and how they are managing in general. The Case Manager worked with the residents to motivate them and would re-adjust their RAPs if needed.

Unfortunately, limited data was available to determine the program's compliance with the following best practice: *Used positive reinforcement and encouragement for achievements.* Despite this, the program achieved a high degree of compliance with client-centred approach.

3.5. Sustainability Plan

Through the course of the funding period, the program's sustainability efforts have been successful. Currently, the RRP services are being funded in part by the Ministry of the Attorney General (MAG), Correctional Services Canada (CSC), United Way, and Reaching Home. Additionally, for residents who are not accessing services through MAG or CSC, they have been accessing the rent subsidy program through OW.

JHS-Thunder Bay has also received funding to support the Recreational Therapist component of the program through the United Way.

Over the past three years, JHS-Thunder Bay have submitted approximately 24 funding applications through 13 different funders. Of those submissions, JHS-Thunder Bay were successful with 21 applications across 11 funders. A list of the submissions and successful applications are provided in Table 11 below.

Table 11: JHS-Thunder Bay Sustainability Plan

Funder	# of Applications Submitted	# of Successful Applications
United Way of Thunder Bay	4	4
Ministry of Children, Community and Social Services (MCCSS): Capital Improvement Fund	3	2
Copperfin Credit Union: Capital Improvement Fund	1	1
Ministry Of Community Safety & Correctional Services (SolGen)	1	1
Ontario Trillium Foundation	1	1
The District of Thunder Bay Social Services Administration Board (TBDSSAB)	2	2
Thunder Bay Police: Project Prevent	1	1
Government of Canada: Reaching Home	3	3
Thunder Bay Community Foundation	1	0
John Andrews Foundation	1	0
Second Harvest	1	1
Canada Summer Jobs	3	3
Metis Nation of Ontario	2	2
Total	24	21

3.6. Discussion of Process & Monitoring Findings

The Residential Reintegration Program's (RRP) process and monitoring evaluation aimed to assess the program's performance as it related to the program's participants, the services & supports delivered, program satisfaction, and its sustainability plan. Over the course of the data collection period, RRP's 47-unit facility had a high occupancy rate of 32 (not counting the 11 units made available to Community Residential Facility clients). Despite the high occupancy rates the evaluation was not able to recruit the target 75 participants. While the evaluation was on track to

recruit more than the target number of clients, the pandemic drastically impacted the operations of the RRP and the evaluation. Despite the pandemic and the lower than anticipated evaluation participants, the program was successful in reaching most of its targets over the course of the data collection period.

The program was successful in recruiting residents from the target group with a diverse demographic profile. Unsurprisingly the characteristics and demographic profile of RRP residents were male and young (18 – 34 years old). The majority identified as Indigenous or First Nations. Justice-involvement, mental health and substance use issues, education and employment issues were also high among the residents.

Program residents also had a diverse demographic profile, with both male and female representation and a diverse age range. The majority of participants were Indigenous, which reflects the over-representation of Indigenous people experiencing homelessness and justice involvement in Canada more broadly. Residents at RRP also had other diverse needs/challenges, including substance use issues, mental and physical health issues as well as employment and education needs.

Close to half (47%) of the program's residents had experienced homelessness in the past 12 months and the majority (59%) of residents had also experienced incarceration. Of those that had experienced homeless in the past year, a quarter (n=6) had been homeless three times or more in the past. There were some unanticipated findings as well, as a large share (80%) of residents have children. Complicating these familial matters is that most of the residents reported they were single (67%) and unemployed (78%). This is noteworthy considering research elsewhere on homelessness has tended to document the experiences of single males without children.[25] The RRP has a mix of young Indigenous males and females who have children living outside of the residence, which creates unique dynamics for the types of family supports RRP residents need outside of the residence.

The program's resident profile suggests that the program is very successful in recruiting the appropriate and high need/risk individuals to reside at the RRP. The residents exhibited a range of issues best served by RRP's client-centred and wraparound approach. Lastly, COVID-19 does not seem to have impacted RRP's target population and outreach efforts, as the program continued to attract high needs individuals experiencing homelessness, despite the challenges of the pandemic.

In regard to occupancy at RRP, the pandemic had two major impacts on the program. Firstly, there was a gradual reduction in residence utilization. There was a decrease in the average number of residents from 33 prior to the COVID-19 pandemic to 29 residents during the pandemic. This gradual decline was largely as a result of the reduction in staffing and health precautions put in place by JHS-Thunder Bay, thus limiting the capacity of the program to recruit

[25] See "Single Males: The Homeless Majority." (2001) Available at: https://nhchc.org/wp-content/uploads/2019/08/June2001HealingHands.pdf; & Katz, M. H. (2017). Homelessness—challenges and progress. *Jama*, *318*(23), 2293-2294.

and intake clients. Furthermore, staff and management reported that the pandemic increased awareness of homelessness in the community, allowing for more supports and services for potential residents and thereby reducing the pressure on the RRP.

Secondly, the pandemic also had an impact of increasing the length of stay for residents. Length of stay for residents ranged drastically depending on need and circumstances. On average residents stayed at the RRP for approximately 7 months. During the pandemic, residents in Cohorts 2 and 3 chose to stay significantly longer than those in Cohort 1. This increase in length of stay was perhaps as a result of the uncertainty many residents experienced as a result of COVID-19 and the increased difficulty in finding employment, housing and other core services required to live independently.

The RRP's approach to a client-centred model of service delivery included development of goals by residents (in conjunction with Case Managers). Residents' goals ranged depending on needs and experiences, however, the vast majority focused on tangible and achievable outcomes such as employment, education, mental health supports and housing needs.

Data indicates that progress towards goals and managing life demands was not a steady process and there were frequent moments of setback. These setbacks represent the reality of working and supporting individuals with multiple risks factors, needs and challenges. The COVID-19 pandemic also had significant impact on individuals' ability to engage in pro-social activities including limitations on education, employment, and access community services. These challenges were exacerbated by greater sense of isolation and a feeling of disconnect because of social distancing and health restrictions at the residence. Despite this, on average, working with RRP staff and accessing supports and services allowed individuals to make progress towards their goals and better manage life demands.

The Recreational Therapy and Social Navigator components are unique aspects of RRP. Despite the limitations imposed by the pandemic, 38 of the residents involved in the evaluation attended at least one of the 330 recreational events. In total there were over 700 instances of participation (across all residents and clients of JHS-Thunder Bay) in the various recreational programs offered by RRP. Recreational Therapy sessions were offered in group and individual sessions and covered a range of different activities (cultural, life skills, socialization etc). During the pandemic, activities were offered remotely using tablets and online conference software. Due to the shift to remote programming the engagement levels of residents in recreational therapy declined compared to pre-pandemic period. This can be attributed to a number of factors including the limitation of online software, residents preferring in-person activities, and the increased need to have individualized sessions to meet the various needs of residents.

The Social Navigator component connected residents ready to transition into the community to provide ongoing social navigation and support. The Social Navigator successfully contacted a total of 169 residents and provided 16 with a place to live in the community. Like Recreational Therapy, the pandemic also had an impact on the activities of the Social Navigator. The majority of available evaluation data on the Social Navigator component was from Cohort 1. The low numbers in the social navigator program in Cohorts 2 and 3 can be attributed to the health and

social distancing restrictions limiting the amount of engagement with residents. More importantly, residents who were in RRP during the pandemic stayed considerably longer than those who were not in RRP at the onset of the pandemic. Thus, there was a minimal need to support individuals aiming to transition into the community. The pandemic also resulted in a shift to the priorities of the Social Navigator position. Increased community awareness and response to homelessness in Thunder Bay allowed a growth in the services and options for individuals at-risk of homelessness. As a result, JHS-Thunder Bay leveraged the Social Navigator position to support individuals in the community in finding and connecting to services as needed. In addition, the Social Navigator position also experienced staff turnover in late 2020.

The program received a high level of satisfaction. Both residents and program stakeholders were very satisfied with various aspects of the program. Residents reported that after being involved in the program, they have noticed positive changes across various aspects of their life and the program, positively impacting their lives. Overall, residents reported that the program had helped them achieve their goals, reduce homelessness, maintain sobriety, develop life skills, and build relationships. Similarly, program stakeholders were satisfied with communication with the program, their involvement with the program, the positive impact the program has on clients, and program staff. All stakeholders shared that they would recommend this program to others, and many believe that the program makes a positive difference in the lives of vulnerable clients with unique needs.

Overall, the process and monitoring findings of RRP indicate that the program was successful in recruiting the appropriate residents and delivering the various program components of the program. The program successfully utilized a client-centred approach and received a high degree of satisfaction from residents and stakeholders. The program has also continued to receive funding to continue to support the Recreational Therapy component. Despite the challenges brought on by the COVID-19 pandemic the program was able to pivot and continue to provide crucial supports and services to residents and the Thunder Bay community as a whole.

4. OUTCOME EVALUATION FINDINGS

The outcome evaluation centres on the impact of the Residential Reintegration Program (RRP) on residents, which presents its own challenges. The client-centred approach of RRP produces a diverse variety of outcomes for residents. The program leverages the resident's strengths to assist them in achieving their goals. The findings below are the culmination of earnest attempts to document and categorize as many of these outcomes for residents as possible. However, the transient nature of RRP residents and the abrupt exit for some, combined with halting data collection due to COVID-19, meant not all these outcomes could be captured. This evaluation could not provide an exhaustive investigation of the anticipated and unanticipated outcomes obtained by every individual who stayed at the RRP over the course of data collection.

In light of these feasibility constraints, the outcome evaluation findings concentrate on the five overarching aims of RRP in order for residents to transition to housing in the community:

1. Obtain housing in the community after leaving RRP.
2. Increase awareness from clients of their needs and the services available to address them.
3. Improve independent living skills, including life skills (e.g., cooking, finance, nutrition, etc.) and emotional regulation.
4. Bolstering protective factors associated with reduced criminal justice contact and housing instability, specifically, participation in pro-social activities, employment, and/or education.
5. Reduce the criminogenic risks of residents.

This outcome evaluation assesses the extent to which the 56 residents of RRP who consented to the evaluation improved across these five areas. Although the findings below are not representative of all individuals who resided at RRP over the course of the evaluation, the analysis below provides a general understanding of the outcomes emanating from the program.

The outcome evaluation is the result of a mix of quantitative and qualitative data to triangulate and showcase the most salient findings. The results under each of the aforementioned five areas rely on data collected through quantitative assessments and surveys (e.g., pre-post and SPIn,), and qualitative analysis of the case notes (e.g., coding of over 700 pages of resident case files) and interviews with residents and staff. The samples for the quantitative data are small, limiting the Evaluation Team's ability to conduct statistical analyses. For example, 15 residents had pre-post test assessments completed, only 10 residents had a SPIn assessment at intake and the 6-month interval. Two residents had the SPIn assessment at the 12-month interval, and four had it done at program exit. The small samples can be attributable to COVID-19 as it hindered the possibility of RRP staff and the Evaluation Team meeting and supporting residents to complete assessments.

As a result of this limited sample, a greater emphasis was placed on filling the gaps through qualitative data. Interviews offered residents the opportunity to relay in their own words the benefits and challenges in residing at the RRP. Accompanied by an honorarium, the interviews provided a greater incentive for residents to participate rather than remotely completing assessments. The Evaluation Team was able to remotely conduct 12 interviews with 10 residents prior to ending data collection. This was complemented with a thorough analysis and coding of case files, and seven interviews with RRP staff. The qualitative results are presented in order of their importance, whereby the most prominent theme found after coding the interviews and case notes is presented first, followed by the second and third most salient themes. The outcome evaluation concludes with a discussion of the results in relation to the Poverty Reduction Indicators the RRP targeted.

4.1. Transition to Housing in the Community

The Social Navigator at RRP was largely responsible for facilitating a successful transition to housing in the community for residents of RRP. Section 3.2.5. of the process and monitoring findings described, in detail, the role of the Social Navigator, and noted the positive outcomes

relayed by residents who worked with the Social Navigator. The 16 individuals who were rehoused can be attributed to the work of the Social Navigator. For a broader review of housing outcomes experienced by RRP residents, the Evaluation Team reviewed each of the 56 resident's case notes.

Through the case notes, the Evaluation Team determined the reason for a resident's file being closed or determined cases where residents had clearly moved to new housing. Table 12 provides a breakdown of the outcomes experienced by residents who exited RRP by the end of the data collection. Residents who were part of the evaluation but still living at RRP by the end of data collection were excluded from the analysis in Table 12 below. Moreover, residents who were deceased or in custody for a matter separate from their bail were also removed from the analysis. Table 12 provides an overall picture of how many individuals exited RRP, and how many of them left housing insecurity a constant.

Table 12: Outcome for Residents Exiting RRP by Data Collection End (July 2021)

Outcome	#	%
Secured housing after leaving	19	40.4
Breached from BVSP	12	25.5
Evicted from RRP	3	6.4
Whereabouts unknown	13	27.7
Total	**47**	**100**

Table 12 indicates that a substantial portion of those who left RRP were able to secure some form of housing upon exit. For many, this included other housing programs or resettling with family—often in other provinces or cities. Housing precarity likely remains an issue for the 40% of RRP residents who left with housing. Nonetheless, the RRP may provide a pathway for former residents to re-settle into the community or their social support network. The RRP may serve as a launchpad for residents on their journey towards greater housing security on the housing continuum.[26] The difficulty in securing housing and maintaining contact with transient populations is evident given that 28% of residents left RRP with the program unable to find their whereabouts.

Despite the relative success in transitioning a transient population to housing in the community, the proportion of residents who were breached by the BVSP is an area of concern. A quarter of RRP residents had their housing placed in jeopardy due to a BVSP breach. While it is outside of the scope of this evaluation to examine whether these breaches were for substantive offences or merely breaches of conditions, the impact of bail conditions and the spectre of returning to pre-trial detention loom large on residents.

[26] See page 1 of https://assets.cmhc-schl.gc.ca/sf/project/cmhc/pdfs/content/en/housing-action-plans-guide-for-municipalities.pdf?rev=e78806ce-72a6-4c8e-9ef7-9ff73960e69b

4.2. Awareness of Needs & Services

In the pre-post assessment, RRP residents reported a significant improvement in their confidence in accessing services in the community in their follow-up assessments compared to when they first started the program. A paired samples t-test involving 15 residents and their pre and post assessments found that they were more confident in accessing services in the community in their follow-up compared to when they first entered RRP (t (14) = 2.78, $p < 0.05$). The size of this effect was large, as indicated by a Cohen's d of 0.89. Hence, residents substantially improved their confidence in accessing services, and this difference is unlikely to have occurred merely by chance.

Improving the confidence of residents is a particularly noteworthy finding because the Evaluation Team found a relationship at intake between confidence in accessing services and life skills, as well as an improved sense of having a social support network. There was a strong positive correlation between confidence in accessing services in the community and scoring higher on their coping and life skills; (r(43)= .62, $p < 0.001$). Those who scored higher at intake in their confidence in accessing services in the community also scored higher on the degree of social support they felt they could rely on; (r(43)= .41, $p < 0.01$). Hence, there is a relationship between having confidence in accessing supports in the community, and residents reporting an ability to cope with stress and feel that there is social support they can rely on. Table 13 provides the findings from the Pearson's correlations for measures taken at intake.

Table 13: Pearson's Correlations (*r*) for Measures at Intake for RRP Participants

Measure	Average Score on Confidence in Accessing Services in the Community†	Average Score on Self Rating of How Skilled they are in Coping and Life Skills‡	Average Score on Social Support⁾(
Average Score on Confidence in Accessing Services in the Community	1	.623**	.407**
Average Score on Self Rating of How Skilled they are in Coping and Life Skills	-	1	0.275
Average Score on Social Support	-	-	1

** Correlation is significant at the 0.01 level (2-tailed).
N=45

Directions:
† High scores=high confidence in obtaining community service supports
‡ High scores=feeling very skilled in in life skills
⁾(High scores=strong social support network

It is critical to keep in mind that correlation does not equal causation. Therefore, improving life skills and having a strong sense of social support may lead to improved confidence in accessing

services in the community, rather than vice versa as indicated above. The relationships displayed in Table 13 cannot determine the causal direction of the relationship. One possibility which cannot be dismissed is that RRP residents who have confidence in accessing services in the community may feel a strong sense of social support from the services they receive. Improving confidence in accessing supports may produce a snowball effect leading to a stronger feeling of having a social support network, and feelings of having the necessary coping and life skills to resolve their concerns.

Outcomes for residents' awareness of their needs and the services available to address them were primarily measured through pre-post assessments and client interviews. Through interviews, residents showed an increased acceptance of their need for support from others, an awareness of their mental health needs, and an understanding of the impact that toxic relationships and environments had on their well-being. Further, residents showed an increased awareness in how to obtain community assistance services available such as reaching out to JHS staff to address employment and housing needs, mental health treatment and counselling programs, and accessing OW/ODSP.

The following section provides a review of the case notes and transcripts from interviews which revealed more in-depth awareness of needs and services from residents.

Awareness of Needs

Residents from all cohorts showed an increased acceptance of needing support, whether it was from staff, friends, or family. Residents commonly sought-after support for their substance use and mental health, explaining that RRP has given them a better understanding of what is needed in order to make better choices. Some residents also discussed that since joining the program, they have been able to focus on themselves and work on building better relationships with their family. Importantly, residents divulged through the interviews that they did not feel judged for needing these supports from the program.

"Just having the support to stay sober…nobody criticizes me for being depressed…being supportive on mental health…they are understanding with things and pointing me in the right direction, you know, just being a product of the residential school system."

- Resident – Cohort 2, Interview

"Now it's like grief and loss. I lost something at the point of letting it go, and how I am gonna go forward? I'm starting to have a better relationship with my two kids, and their father…being here has helped me to make better choices and be around better people; where I want to be and don't want to be."

- Resident – Cohort 3, Interview

The supports residents accessed through RRP supported them in creating stability in their lives and allowed them to commit to improving their overall quality of life by taking the time to shift their focus to self-care and -recovery. Residents discussed stability in terms of having a place to stay in the residence, being able to focus on their sobriety and working towards stable housing in the community. Living within the residence provided a safe and comfortable space where residents could settle in, catch up on sleep, take care of themselves, and focus on their mental well-being. One resident, who was a returning client to JHS-Thunder Bay, shared that they would not have survived if they had gone anywhere else:

"I came here because this was the only place I know… If I went anywhere else, I would have died on the street."

- Resident – Cohort 3, Interview

Other residents indicated that they were dedicated to working towards a better life using the support at RRP:

"It's taken me a long time to feel safe and comfortable, and not afraid…even to leave the property because of what I was living before…I moved to a different part of town to be here, and I needed that, so I don't go back to my relationship. Because going backwards will only keep me not good enough, not healthy, not safe. I am learning who I am, because I was more or less thinking about everybody else, and not myself."

- Resident – Cohort 3, Interview

Residents discussed their awareness and understanding of their mental health needs as it relates to alcohol use, physical health, medication, past trauma, and psychological supports and treatment. Some residents shared that the challenges with their mental health stemmed from excessive substance use that led to physical health implications and suicidal ideation. This turned into a cycle of issues arising and using substances to cope which worsened residents' health.

"Before I moved into John Howard, before I went to jail, I had so many problems in my life happening all at once. All I was doing was drinking, I didn't really care. Before my problems with health, I had a really a good life… I had anything I wanted, could do anything I wanted, could travel the world. Then I had almost had a heart attack, I had a double bypass, had my license taken away because of it, had my job taken away; I had no income… I was down to the point where I didn't wanna live anymore. So, I just started drinking, I knew drinking would kill me eventually. So, I started drinking excessively every day"

- Resident – Cohort 2, Interview

Since joining RRP, residents had the space available to address both their mental and physical health issues as well as their substance use. Through accessing supports such as Alcoholics

Anonymous (AA), and mental health counselling, and treatments, residents were able to maintain their sobriety and improve their mental well-being.

"…when I got to John Howard, I had my own personal space, going to AA meetings, talking to a psychologist, and you know, I just got away from that steady suicidal thinking and being able to make a little better life and surviving than I did before."

- Resident – Cohort 2, Interview

Residents were also aware and understood that they can be set back when trying to address their own needs through their relationships and environments. Residents identified these relationships and environments as toxic situations involving individuals they associate with, relationships with their family or past or current romantic partnerships. Within these situations, residents experienced isolation, mental and emotional abuse, feelings of discomfort, and a lack of safety. Through their time at RRP, residents have slowly progressed to feeling safe again and developed a sense of resiliency. JHS staff worked alongside residents providing supports for safety including strategies to protect themselves from toxic environments, assisting residents in retrieving belongings from previous partners, and being available to talk when residents felt triggered by their past.

"It's helped me to focus more on myself, and not backwards. Talking with [staff] – they keep reminding me that that's the past, and you gotta try and work on yourself and where I wanna go."

- Resident – Cohort 3, Interview

Awareness of Services

Residents from all cohorts showed an increased awareness in how to obtain community assistance such as reaching out to RRP staff. Residents often connected with staff when they needed assistance for their employment and housing, specifically from the Social Navigator. Residents from Cohorts 1 and 2 focused on resume building, job searching, receiving referrals to YES employment, getting information for disclosing a criminal record, and assistance with purchasing items for work such as boots. In addition, residents in Cohort 2 received assistance with language and literacy barriers, completing employment-related certificates, and received knowledge of any job openings in the community from staff. Residents from both Cohorts 1 and 2 handed out resumes and gained employment. For more information on residents' employment outcomes, see Section 4.4.2**.** Moreover, residents from Cohort 3 were able to obtain assistance for employment and housing during the COVID-19 pandemic. Those in Cohort 3 worked on registering for a Smart Serve course through Elizabeth Fry, received referrals to community agencies for housing support, worked with YES employment virtually, and relied on staff as they recognized them as a source of community support.

"Yeah, all I have to do is ask someone for help and they'll help me."

- Resident – Cohort 3, Interview

"They referred me to another agency that's helping me with housing. They're working together with me for what I am gonna need now and in the future, like helping me to look for an apartment. I can't handle too much, I only need one thing at a time, it's like, looking for an apartment, and then like, counselling. I can't handle too much because I think that would set me up to fail, like that's the type of person I am, and they are aware of that."

- Resident – Cohort 3, Interview

Through the Social Navigator, residents were able to receive one-on-one support for their housing needs including filling out applications and viewing apartments in the community together. For some residents, this also included coordinating with other agencies in the community that residents accessed such as the Canadian Mental Health Association. The Social Navigator was also able to support residents as a confidant and someone that they could rely on.

"There's a housing girl. We go to her for housing, I filled out an application. We went to look at apartments together – just talking about what kind of neighborhood, if I'm ready to move, what part of town. She's there to help. The worker here talks to the worker at the Canadian Mental Health, so they both know what's going on with me. They both come with me to look at housing. If I was on my own, I would've been late or missed an appointment. We all did it together. It helps me being able to do it. Going through the whole process, it is not so scary; I need them by my side. Because I am used to having my boyfriend with me, and it's hard, even though it wasn't a healthy relationship, it is still hard for me to learn and do stuff on my own."

- Resident – Cohort 3, Interview

In addition to employment and housing, residents were able to rely on staff day-to-day when they needed someone to talk to.

"Each staff member – I am comfortable talking to them, whether they are a man or woman or whatever person is available at that time. I can sit and talk to them about my day or what might be bothering me at the time. If things happen in my life, you know, I'm the same as other people here, it's not like I haven't been charged before, like, everyone's human, no one's perfect, and like, the staff, they don't treat you like you are different than anybody else. I can talk to them about what might be bothering me or might not be good. Even if it's the maintenance guy."

- Resident – Cohort 3, Interview

Residents from Cohort 2 and 3 showed an increased awareness in obtaining professional help in terms of mental health, physical health, and treatment programs. Residents from Cohort 2 shared that they have attended AA programs and the *Breakfast Club* at the Smith Clinic. To apply for these treatment centres, residents discussed receiving assistance from the Bail Program at JHS-Thunder Bay and RRP staff. Attending these programs not only allowed residents to focus on

their needs, but also provided the opportunity to build relationships with others. This was especially valuable for those residents that felt isolated from their family and culture.

"I'm not near my First Nation or my family so most of my contacts are through my AA program and also, I attend this clinic called the Breakfast Club. They are older adults… It's just a Tuesday morning, it used to be a breakfast club where we met and had some breakfast at the treatment centre, the nurses would make us breakfast and we would have a couple discussions, watch some videos. It usually lasted about 3-4 hours in the morning. But again because of COVID, we don't do that anymore."

- Resident – Cohort 2, Interview

Residents from Cohort 3 also focused on accessing OW with the assistance of the Social Navigator.

"I got my disability paperwork from the Ontario Works, and I have a deadline of August 31st…I have a pamphlet that I haven't opened up yet, but on Monday, I plan on viewing it with one of the Social Navigators."

- Resident – Cohort 3, Interview

The residence provided a safe space for residents to understand and address their complex needs. The residence provided individuals with the necessary supports, resources, and stability to properly address their needs and improve their overall quality of life. Residents discussed being able to focus on and seek assistance with a realm of needs such as mental health, substance use, physical health, past trauma, and unhealthy relationships. Residents also showed an increased awareness in how to obtain community assistance by reaching out to the staff RRP, specifically for their housing and employment needs. Not only do residents reach out to the staff when seeking help with resources and supports, they also feel comfortable and safe approaching staff when they need someone to talk to about personal matters.

4.3. Independent Living Skills

Outcomes for residents improved independent living skills were primarily measured through pre-post assessments, case notes, and client interviews. A paired samples t-test involving 15 residents did not find statistically significant differences between resident's pre- and post-test self-reported measures on independent living and life skills; (t (14) = 1.58, p = .135). Nonetheless, through interviews, residents showed an improvement in their life skills by maintaining sanitary conditions, attending life skills programming offered at the Residential Reintegration Program (RRP), and working towards goals set out in their Resident Action Plans (RAP). Residents also showed an improved ability for living independently through their daily routines. Further, residents showed improvements in their emotional regulation, mental well-being, and self-efficacy and use

of social supports. The analysis below provides a summary of these findings from the case notes and interviews.

To get an understanding of how residents were coping and managing their life demands, the Evaluation Team analysed the *Client Status Survey* for the 14 residents who had initial surveys completed within their three months of moving in, and follow-up surveys completed three to six months of moving in (see section 3.2.3.). The *Client Status Survey* asked respondents to rate how well they were managing life demands between a scale 1 (very poor) to 10 (very good). The majority (n=8) of the residents scored themselves higher in their follow-up when asked how they were managing their life demands. Five of these eight respondents had scored two points higher in their follow-up than their initial survey. Three of the residents decreased their scores in their follow-up, and the remaining three did not change from their initial rating.

Following each rating, residents were asked to further elaborate on why they provided the rating on how well they are managing life demands, residents' explanations varied based on whether they reported that it improved, stayed the same, or did not improve. Residents who did report an improvement in their ability to manage life demands reported that they felt supported and safe in RRP, and some noted improved family situations. were more capable of improving their wellbeing through support from the community, addressing their own mental and physical needs, developing coping skills, and having a positive environment. Those who did not have any change in their ability to manage life demands reported that they were still working on their self-healing, reaching opportunities and goals, and learning to adjust. For those who did not improve in managing their life demands, some residents reported that they were having a difficult time adapting to being part of the RRP independently. The following section provides a review of the case notes and transcripts from interviews which revealed more in-depth life skills and ability to live independently from the residents.

Life Skills & Ability to Live Independently

Residents from all cohorts showed an improvement in their life skills and ability to live independently by maintaining sanitary conditions of communal spaces, such as the kitchen or their room, as well as taking the initiative to assist with chores around the residence. The case notes revealed several instances of residents from all cohorts assisting around the residence, including cooking meals for other residents and drop-in clients, washing dishes, cleaning the communal kitchen, and mopping the hallways. Case notes for residents from Cohort 2, more specifically, made mention of the *Residential Cleaning Program* at RRP where residents could clean the residence and programming areas to be rewarded with points or credits that would go towards receiving gift cards or other incentives. Residents made use of the gift cards to purchase food and clothing. Residents from Cohort 2 also had set goals for learning to cook and worked on this through life skills programming and assisting in making communal meals when possible.

In terms of life skills programming, residents from Cohort 1 participated in activities related to budgeting their money. For those in Cohort 2, goals were set out in their RAP for improving their health through working out and creating a self-care routine which included setting an alarm for personal activities (e.g., showering, eating), rewarding oneself after completing a task, and keeping their room tidy. Through interviews, residents from Cohorts 2 and 3 explained that by creating daily routines, they were able to have structure and consistency in their life. One resident

from Cohort 2 discussed how they created a steady routine that involved eating, exercising, working, and socializing. A resident from Cohort 3 also explained that having a daily routine enabled them to be more dedicated to following through with commitments which was something they were unable to do when living on the streets.

"If I signed up for this and I knew it was at 2 – if I was on the street, I'd say 'Ah, I wouldn't do it' – now I'm trying to follow these things."

- Resident, Cohort 3, Interview

Residents in Cohort 3 discussed through interviews that RRP has provided them with the opportunity to focus on themselves by prioritizing their basic daily needs (e.g., eating, cleaning, and sleeping), and also explained the value that the residence has as it provides a stable place to structure their lives.

Emotional Regulation, Mental Well-being & Self-Efficacy

Residents from all cohorts showed an improvement in their emotional regulation and coping skills, mental well-being, and self-efficacy in seeking out social support when needed. Residents strengthened their ability to cope with trauma, the temptation to use substances, and used coping mechanisms and reconciliation in stressful situations. The case notes, specifically, showed instances where residents would be in an emotional or tense situation. In these instances, residents sometimes experienced outbursts where they did not act favourably towards staff. However, after this would happen, residents would take the initiative to cool down and come back to staff to apologize for the way they reacted. This would lead to an explanation of where frustrations stemmed from and allowed staff to provide assistance, reassurance, and coping strategies for the resident to use.

"[Staff] told [the resident] he is allowed to feel frustrated; he just needs to channel it better. [The resident] explained that he has come a long way because he would not have lasted 10 days in JHS before. [Staff] told [the resident] that they want to see him succeed."

- Resident, Cohort 2, Case Notes

Further, in situations where residents experienced heightened emotions regarding their personal matters, staff would work with residents to itemize what the resident could focus on to achieve a better outcome/solution. Case notes revealed situations with residents from Cohorts 1 and 2 experiencing emotions such as being overwhelmed, struggling, and feeling frustrated. By working with staff, and specifically the Mental Health Support Worker (MHSW) at JHS, residents discussed coping strategies to respond to these feelings and emotions. In particular, residents in Cohort 2, discussed their increased use of healthy coping mechanisms which has been a personal improvement that they expressed pride in. Residents from this cohort would connect with staff to ask for coping techniques they could use when feeling anxious or tempted to use substances. Residents from Cohort 3 discussed their struggle with trauma which impacted their urge to use substances in order to self-medicate. However, residents explained that they have pushed themselves to talk to staff when they feel this urge to help process their feelings instead.

Residents from all cohorts showed experiences of stress, feelings of hopelessness and helplessness, and a sense of being disconnected. However, residents would often connect and confide in the MHSW to share their trauma and experiences. Many residents were reluctant to categorize this as 'mental health' and explained that they just needed someone to talk to about their struggles in life. Residents from Cohort 1 struggled with their mental health, had suicidal ideation, experienced high stress levels, and discussed feelings of helplessness. These residents confided in the MHSW when feeling low, particularly as a result of substance use, familial issues, and struggling with depression after moving out of JHS-Thunder Bay. The MHSW worked with these residents to discuss strategies to cope with emotions and stress.

Residents from Cohort 2 experienced stress, challenges in dealing with their anger, and grieving the loss of family members and friends. These residents connected with staff (including the MHSW) to request assistance in accessing mental health resources and coping techniques such as anger management tools. One resident was referred to an external agency, however, they explained that they prefer speaking with staff at JHS about their concerns. Residents from Cohort 3 also discussed experiencing grief and stress; however, their challenges were heightened due to COVID-19. For example, residents from this cohort were more likely to discuss financial stress than residents in other cohorts. These residents also experienced isolation due to the lockdown and discussed feeling disconnected from their families. Staff connected with these residents to address these challenges such as leniency on being late on rent and encouraging residents to reach out to talk to any staff available when needed.

Overall, residents from all cohorts sought out resources when they needed supports. Residents from Cohort 1 accessed services to address medical needs, mental health, and employment needs. These residents worked with staff about treatment options, referrals to supports such as the RAAM clinic at NorWest Community Health Centre, and housing assistance when residents were homeless after leaving RRP. Residents from Cohort 2 accessed programs at JHS and other agencies when they recognized that they needed to work through issues, expressed interest in finding support for FASD-related resources, and connected with staff when they felt they were spiralling. Residents from Cohort 3 relied on connecting with staff, specifically the MHSW, as referrals to external agencies were reduced due to COVID-19.

For those most part, residents demonstrated an increased ability to live independently, as they reported an increased ability to manage life demands, improved life skills, and ability to engage in emotional regulation and self-efficacy. Most residents reported that they improved their ability to manage life demands; however, for those that did not improve, they indicated that they were still working on their self-healing, reaching opportunities and goals, or were having a difficult time adapting to being part of the RRP independently. Additionally, all residents showed an improvement in their life skills through their involvement in various activities such as maintaining the sanitary conditions of the kitchen or their room, assisting with chores around the residence, learning about budgeting money. As well, residents set out goals in the RAP related to setting a daily routine (e.g., setting an alarm, keeping room clean, exercising), which enabled them to be more dedicated to following through with commitments which was something they found challenging prior to moving into the residence. Lastly, residents showed an improvement in their ability to engage in emotional regulation and coping skills through seeking out social support when needed. Throughout the program, residents experienced situations where their emotions were heightened, which RRP staff and counselling services were able to help them through,

assisting residents in developing healthy coping mechanisms. Additionally, residents took the initiative to work with mental health counselling services to address challenges such as coping with trauma and substance use. RRP has provided residents with the opportunity to focus on themselves by prioritizing their basic daily (e.g., eating, cleaning, and sleeping) and emotional needs while providing stability in their lives.

4.4. Protective Factors

Outcomes for residents bolstering protective factors associated with reduced criminal justice contact and housing instability were primarily measured through pre-post assessments, case notes, and client interviews.

4.4.1. Engagement in Pro-Social Activities

Residents from all cohorts demonstrated an improved awareness of the benefits of, and motivation to participate in, recreational activities as it provided health benefits, the opportunity to develop pro-social relationships among residents, and connected residents with their culture.

Residents from Cohorts 2 and 3 expressed an interest in a wide range of activities that promoted health benefits and aided in stress relief. Through interviews, residents explained that they enjoyed engaging in physical activities such as walking, hiking, or working out to improve mobility and cardiovascular strength, to relieve stress, and to keep busy. Additionally, some residents shared that they found cleaning or walking a dog to be a beneficial activity in relieving stress.

"I wanted something to do other than sitting in my room and feeling sorry for myself. I do a lot of walking; I walk about 12k steps a day."

- Resident, Cohort 2, Interview

"I like to clean so, I clean a lot, that's how I work out my stress – when I feel tightened up inside, I clean."

- Resident, Cohort 3, Interview

Across all cohorts, residents indicated that group activities and programming provided them with a therapeutic outlet as it allowed them to cope with negative experiences from their past. There were many instances reported, particularly during cultural activities, where residents felt comfortable opening up about their past traumatic experiences, whether it was unresolved childhood trauma, previous abusive relationships or dealing with grief. Cultural activities proved to be a crucial and important component of the program as it allowed residents to heal from negative experiences and feelings from their past.

Additionally, residents established healthy coping mechanisms through participating in life skills and arts-based activities such as cooking and music. Throughout their participation, residents articulated that they engaged in certain activities to help cope and manage their daily life stressors such as their justice involvement, mental health concerns, and familial and/or child custody issues.

"[The] resident spoke about how he utilizes cooking as a coping mechanism as well as a way for him to give back to those around him."

- Resident, Cohort 2, Case Notes

"[The] resident shared a country song about focusing on the good things in life. The song helps them remember that when you are experiencing a bad time, there is something good waiting around the corner."

- Resident, Cohort 2, Case Notes

Residents across all cohorts shared that engaging in activities offered through RRP has allowed them to build pro-social relationships with other residents living in the building. Participating in group activities (e.g., day trips, cooking, crafts, move nights) allowed residents to build relationships and connect with other residents that they may not have otherwise engaged with. Some residents shared that they enjoyed the social atmosphere that these activities offered. One resident shared their experience engaging in a group activity that was specifically for female residents explaining that it provided the opportunity to bond with and support one another.

Additionally, group programming often resulted in residents sharing information amongst one another to help each other out with challenges that they were facing. Over the course of the program, there were instances of residents sharing information about how to complete OW housing forms, sharing information about sacred medicines, and sharing traditional stories. There were also cases where residents used the information that they learned through programming to share with others and their community. For example, one resident attended an employment information session and was interested in more information that they could provide to the youth in their home community.

As mentioned previously, cultural activities (i.e., traditional medicine teachings, yoga, sweat lodge, smudging) had a significant impact on residents. Cultural activities have allowed residents to take the time to learn more about themselves, re-connect with their culture, and work towards their health and sobriety. Engaging in cultural activities had such a significant impact on some residents from Cohorts 1 and 2 that they were eager to include their loved ones in the activities.

4.4.2. Employment & Education

Employment

The SPIn assessment was administered at intake, program exit, and at 6-month and 12-month follow-ups. Through the assessment, residents were asked if they were currently employed at each of the aforementioned intervals. Three of the 10 residents had noted at intake that they were employed at the time of intake; however, only one of these residents retained their employment by their follow-up assessment at 6-months. One resident who was not employed at the time of intake noted that they were employed by the time of their 6-month follow-up assessment. The remaining residents did not indicate they were employed at any other intervals of the SPIn assessment.

The pre-post assessment also asked residents if they were currently employed at the time of administering the assessment. From the 56 residents who consented to the evaluation, only 15 had pre-post assessments completed. Two residents who noted they were employed at the time of the pre-test had retained their employment by the time of the post-test. One of the two residents noted that they had shifted from part-time at the pre-test to full-time by their post-test. The remaining 13 residents did not report they were employed at either the pre or post-test intervals.

Case notes and interviews provided a more in-depth analysis of residents' experiences with employment. Case notes indicated that a handful of residents were successful in finding and maintaining employment, or other forms of sustainable income. This was done through actively seeking employment opportunities, volunteering, or by securing part-time or full-time employment. These opportunities were largely sought from residents in Cohorts 1 and 2.

Some residents indicated that they were actively seeking employment, a process in which they were supported by RRP staff. Residents received help from RRP staff to update cover letters and resumes and residents reported various incidents where they were actively applying and interviewing for job opportunities. Residents also worked with YES employment for pre-employment support and to learn about job opportunities. Some residents engaged in volunteer opportunities, which they found to be both rewarding and enjoyable.

Additionally, some residents were successful in obtaining employment during their involvement with the program. One resident obtained a casual job, two were offered cash jobs , while seven residents were successful in obtaining part-time or full-time jobs either during or after their stay at JHS-Thunder Bay. Alternatively, one individual was fired, and another had to leave their job due to their curfew conditions. The jobs secured by residents were among the food and service industry, construction, or the trades (e.g., welding).

Education

During their time in the program residents expressed interest in or were successful in improving their educational status. This was demonstrated only among residents from Cohorts 1 and 2.

Three residents expressed that they were interested in completing their high school education or writing the GED exam, while two residents had signed up to obtain their high school diploma

during their time in the program. Four residents were either referred to or attending the Adult & Career Entrance (ACE) program at Lakehead University, while three residents expressed interest in attending. In terms of post-secondary education, two residents expressed interest in enrolling in a college program or class, one resident started going back to college, and two residents completed training and certificates to improve their chances of gaining employment.

"I started to go to college. I didn't need upgrading, but I had like the GED… I am planning on going back to school, so they showed me the way to get some courses, some hard level algebra and chemistry, English and technical writing courses – just so when I decide to enroll in a college program."

- Resident, Cohort 2, Interview

Residents were involved in various activities to improve protective factors to work towards their goals and move towards housing stability. Residents demonstrated an improved awareness of the benefits to participating in recreational activities such a walking, working out, or cleaning, as they provide health benefits and relieved stress. Residents also believed that engaging in group activities, such as day trips, allowed them to develop pro-social relationships with others in the residence, since they were able to socialize and bond with others with similar experiences to them. It also provided the opportunity for residents to share information with each other to help each other out. Cultural activities had a significant impact on residents, as they allowed residents to take the time to learn more about themselves, re-connect with their culture, and work towards their health and sobriety. Residents were also able to establish healthy coping mechanisms through life skills and arts-based activities such as cooking and music. These activities helped them cope and manage their daily life stressors such as their justice involvement, mental health concerns, and familial and/or child custody issues.

The program also provided residents with the resources and supports to seek out employment and/or education opportunities. A handful of residents were successful in finding and maintaining employment, or other forms of sustainable income through actively seeking or securing employment opportunities and volunteering. Additionally, some residents expressed interest in or were working towards improving their educational status by obtaining their high school education, writing the GED exam, attending an Adult & Career Entrance program, enrolled in a college program, or completing training and certificates to improve their chances of gaining employment.

4.5. Criminogenic Risk

The SPIn includes a variety of static and dynamic factors for program staff to examine the needs and risks of residents. The static factors are those questions which ask about the individual's past behaviour and living circumstances; for instance, if they have a history of aggression or homelessness. The data showcased in the resident profile section of the process and monitoring section largely reported on these static factors. Considering the outcome evaluation is interested in examining change, only findings on dynamic factors across repeat assessments are discussed

here. The dynamic factors analysed amongst the 16 residents who had intake and follow-up assessment were: aggression, substance use, and social influences. The results for the employment questions from the SPIn were addressed in the previous section and are not reiterated below (see section 4.4.2.).

Regarding aggression, the SPIn asks the Case Manager at each of the intervals if the resident has displayed "any violent behaviour recently." On the one hand, two residents were noted as exhibiting violent behaviour at intake but not in their follow-up assessment at the 6-month mark, indicating improvement. On the other hand, two other residents had not displayed violent behaviour at the time of their intake, yet one was noted as displaying violent behaviour in their 6-month follow-up and the other in their 12-months follow-up. Additionally, the SPIn asks the Case Manager to confirm if residents had any "violent encounters with strangers." Three residents were noted as having had a violent encounter with a stranger at intake but had not had such an encounter in their 6-month follow-up. Two residents had not had such a violent encounter at intake but had one by the time of their 6-month follow-up. Four of the residents with follow-up SPIn assessments had not been flagged for any violent behaviour or encounter at either the intake or any follow-ups.

The SPIn assessments recorded the self-reported frequency of substance use for residents on legal substances such as alcohol and cannabis, and illicit substances such as cocaine, crack, and heroine. Twelve residents had follow-up responses on substance use at either the 6-month, 12-month, or program exit intervals. Four of the 12 residents reported reduced alcohol use, while another four reported increased alcohol use, and two reported no change in their alcohol consumption. Cannabis use increased amongst the residents, as six residents indicated their cannabis use increased from their intake assessment. Only two residents noted their cannabis use had decreased from their intake, and the remaining four indicated no change. Regarding illicit drugs substances such as cocaine, crack, and heroine, few residents had reported a change as nine of the 12 had indicated they had not used these drugs at all. One respondent reduced their reported use of cocaine, while another two increased their cocaine use from none to 1-2 days per week, and one increased their crack use from none to 1-2 days per week. Overall, cannabis use increased, while alcohol and illicit substance use remained unchanged for most residents.

Finally, the SPIn recorded the self-reported gang affiliation of residents. Eleven residents had SPIn assessments completed at intake and a follow-up with a response to the gang affiliation questions. The SPIn recorded whether residents "currently belong in a gang" and whether they "associate with people in a gang." None of the 11 residents indicated they belonged to a gang at intake or any of the follow-ups. One resident exhibited improvement away from negative social peers as they indicated "Yes" at their intake that they associated with people in a gang, and then indicated "No" at the time of exiting the Residential Reintegration Program (RRP). However, one resident's negative peer associations worsened, as they noted that they associate with people in a gang at their 6-month follow when they had not indicated it in their intake. The overwhelming majority of residents who had SPIn assessments were not gang affiliated prior to entering RRP and generally continued to abstain from gang involvement over the course of RRP.

As mentioned above, the SPIn measures various static and dynamic factors to examine the needs and risks of program residents. The findings of three dynamic factors were reported in this

section: Aggression, Substance Use and Gang Affiliation. In terms of aggression, between intake and the follow-up, some residents demonstrated a decrease in aggressive behaviours, while some demonstrated an increase. Regarding substance use, cannabis use increased, while alcohol and illicit substance use remained unchanged for most residents. Finally, most residents who had SPIn assessments were not gang affiliated prior to entering RRP and, for the most part, continued to abstain from gang involvement over the course of RRP.

4.6. Discussion of Outcome Findings

This evaluation of the RRP focused on whether residents were able to: secure housing upon exit; improve their awareness of their needs and the services available to address them; improve their independent living skills; bolster protective factors by participating in pro-social activities or gaining employment or education; and lastly reduce their criminogenic risks. In the process of uncovering these findings the Evaluation Team unpacked numerous details which inform "*what is working and for whom"* at RRP.[27] This section of the report provides concluding thoughts on the outcome findings presented above, including an analysis of RRP through a realist evaluation lens.

A considerable portion of residents were able to secure housing at program exit. Over the course of the evaluation, 47 residents exited RRP and 19 of them left RRP housed. In other words, 40% of residents who left RRP did not return immediately to homelessness. Some of these individuals transitioned to private rentals, while others entered other housing programs or resettled with family who lived outside of Thunder Bay. One-quarter of the 47 residents who left had their stay at RRP cut short due to a breach by the BVSP. Another quarter of the 47 residents simply left the residence and their whereabouts could not be confirmed. Half of the residents who left RRP either breached their bail order or left without providing a mechanism for RRP staff to follow-up with them. Thus, providing an exemplar case in the difficulty of working with clients who have complex needs and are often transient. This suggests Evaluators and funders may be better served by tempering expectations for what can be reasonably expected of a transitional housing program. It is not clear whether this 40% success rate provides a ceiling capping the best possible outcome, or a floor to build and improve upon transitional housing supports. Nonetheless, the RRP has proved capable of securing housing for a sizable portion of its residents.

Section 4.2. detailed the potential snowball effect that improving confidence in accessing services may have on emotional regulation and the feeling of having a support network. The pre-post-test analyses found RRP residents were significantly more confident in accessing services in the community in their follow-up compared to when they started at RRP; (t (14) = 2.78, $p < 0.05$), Cohen's d=0.89. This improvement may be attributed to the combination of effective one-to-one case management services and the broader RRP environment. Residents noted in interviews and case notes that the RRP had provided them with the opportunity to focus on themselves by prioritizing their basic daily needs (e.g., eating, cleaning, and sleeping), and providing a stable place to structure their lives. Furthermore, the one-to-one case management supports were popular with residents, as they requested help in a range of tasks, including emotional regulation

[27] Hewitt, Gillian, Sarah Sims, and Ruth Harris. "The Realist Approach to Evaluation Research: An Introduction." *International Journal of Therapy and Rehabilitation*, 19.5 (2012): 250-259.

and filling forms. Emphasizing self-care and personal wellbeing along with offering one-to-one supports were requested likely create an atmosphere where residents can focus on themselves, and on the things which are priorities to them. Consequently, improving their confidence in accessing services and for some it may possibly initiate a path to recovery from the considerable trauma and substance use documented in this report.

More than two-thirds (71%) of the 14 residents who completed initial and follow-up Client Status Surveys noted improved scores how they were managing their life demands. This suggests that as residents settle in to RRP and improve their emotional regulation and ability to respond to their existing challenges. In interview RRP residents articulated how the program provided them an opportunity to create and stick to consistent routines. The RRP may improve the emotional well-being of residents by providing a safe space for residents to make their lives more predictable and certain, compared to precarity inherent in homelessness or incarceration.

In terms of bolstering protective factors, some residents were successful in obtaining employment during their involvement with the program. One resident obtained a casual job, two were offered cash jobs, while seven residents were successful in obtaining part-time or full-time jobs either during or after their stay at JHS-Thunder Bay. Furthermore, two residents had signed up to obtain their high school diploma during their time in the program. Four residents were either referred to or attending the Adult & Career Entrance (ACE) program at Lakehead University, while three residents expressed interest in attending. Where the RRP had the most success in building protective factors for residents was in connecting them to prosocial activities. Residents participated in a total of 330 recreational activities between December 2018 to December 2020. The interviews and case notes revealed the cultural activities to be the most impactful for residents. Cultural activities allowed residents to take the time to learn more about themselves, re-connect with their culture, and work towards their health and sobriety. Emphasizing self-care and discovery for a population with lengthy histories of trauma might provide a gentle landing strip for residents to begin to stabilize their lives. The sample size of SPIn assessments were too small for the Evaluation Team to validate whether RRP effectively reduced criminogenic risks for RRP residents. However, the analysis below describes the trouble in emphasizing criminal justice outcomes when measuring success for a transitional housing program.

Having reiterated the outcome findings above, the Evaluation Team is left with answering "*what is working and for whom"* at RRP? There is no clear or singular answer, yet, what seems to be the key factor is the relationships between residents and staff. The interviews and case notes revealed how these relationships are central in guiding resident participation, and therefore individual outcomes. Residents commonly sought support from Case Managers for their substance use and mental health. A review of the case notes revealed that the client-centred case management supports seem to work particularly for those managing substance use issues and previous trauma. Such individuals leaned heavily on staff to help them with regulating their emotions or when dealing with a challenging circumstance in their life.

More broadly, all residents engaged with both the Recreational Therapist and Social Navigator to pursue their own goals. The majority of residents who had follow-up Client Status Surveys reported improved progress on their goals. These residents often directly cited the work of staff at RRP in helping them fill out forms or refer them to the appropriate counselling or employment supports. The work of the Social Navigator in particularly was able to assist a diverse client group.

This one-to-one work is likely why residents noted improvements in their confidence in accessing services in the community. Between attending pre-natal appointments, to securing housing for clients in the pandemic, the strength of the RRP lies on the flexibility of the program to adapt to the context and needs of its residents. Undoubtedly, the secret sauce of RRP is in its flexibility of its staff and program to adapt to resident and community needs.

If RRP's secret sauce are the staff and the long-term relationships they build with clients, underpinning this is the program's ability to effectively target the right population for its services. The residents who enter RRP have complex needs and many of the needs—particularly in relation to physical health and food insecurity—may require significantly more resources and external partnership. Nonetheless, over the course of data collection the RRP has shown that it retains its focus on clients experiencing homelessness with intersecting criminal justice issues. Staff are experienced in criminal justice matters, as this evaluation has documented their efforts in assisting residents with legal aid applications and bail variations (i.e., change bail orders), all the while maintaining a focus on housing the resident first and foremost. The upshot of working at this intersect between housing and criminal justice matters, is that the criminal justice matters tend to trump housing outcomes.

The success of the one-to-one case management is tempered by the fact a considerable proportion of residents did not obtain their goals or exited the program prematurely—either to a breach or lost contact. In some circumstances, external drivers such as compliance with bail orders reduced the ability for residents to stay in RRP long enough to potentially experience outcomes. Nonetheless, the underlying reality in delivering services for transient populations is that there will be attrition, breaches, and cycling of clients in and out of the program. For RRP to maximize outcomes for residents, it may mean attaching its success more closely to housing outcomes for clients, as opposed to criminal justice and criminogenic outcomes. In other words, move away from viewing reduced risk from SPIn assessments or recidivism—substantive offences or breaches as measures of program success. The recommendations section of this report provides further input on where the RRP can maximise its impact for residents.

4.6.1. Local Poverty Strategy Priority Groups

One of the goals of the Local Poverty Reduction Funding (LPRF) and the RRP program was to address a number of the indicators noted in the Local Poverty Strategy. The primary indicator of Homelessness and those at risk of homelessness has been discussed in length throughout the report, the following section will provide a brief overview of the youth, Indigenous and First Nations, and female residents at the RRP.

As indicated in Section 3.1. of the report, of the 56 residents at the RRP 29% identified as female. Females resided at the RRP for an average of 26 weeks, approximately 4 weeks less than males. Female residents had indicated lower numbers of past incarceration than males, however they had higher rates of homelessness in the 12 months prior to intake. There were more female participants who were 30 years or older as compared to males and were more likely to identify as Indigenous. In addition, female residents were less likely to have completed at least high school and less likely employed (part-time or full-time). Surprisingly, more female residents did indicate

having problems with alcohol yet were less likely to use illicit drugs (see Table 21 below for full breakdown). Although the numbers of female residents were relatively small, data collect does present a small snapshot of the challenges and barriers related to homelessness faced by women in Thunder Bay.

Table 14: Male and Female Resident Comparison			
		Gender	
		Male (n=40)	Female (n=16)
Experienced Homelessness in the last 12 months?		41%	63%
Past Incarceration		68%	38%
Age	18 -29	44%	25%
	30 and over	56%	75%
Ethnicity	Indigenous or First Nations	55%	75%
	White	45%	25%
Not Employed/EI/ODSP		75%	88%
Completed High School?		47%	31%
Problem with Alcohol		38%	50%
Use illicit drugs (at least once a week)		23%	6%
Diagnosed with Mental Health Issues		48%	50%

Most of the residents at the RRP identified as Indigenous or First Nations (61%), compared to 39% who identified as White. As previously discussed, Indigenous residents resided at the RRP for significantly longer White residents (32 weeks and 23 weeks respectively). Indigenous residents were more likely to be younger, to identify as female, to have not completed high school and to indicate having problem with alcohol (see Table 15 below for more details). The fact that the largest proportion of RRP residents identified as Indigenous speaks volumes to the over-representation of Indigenous Peoples in both the justice-system as well as those experiencing homelessness. The impacts of trauma and colonialism continue to present significant challenges and barriers of Indigenous residents in transitioning into the community.

Table 15: Indigenous/First Nations and White Resident Comparison			
		Ethnicity	
		Indigenous (n=34)	White (n=22)
Experienced Homelessness in the last 12 months?		47%	48%
Past Incarceration		53%	68%
Age	18 -29	47%	24%
	30 and over	53%	76%
Gender	Male	65%	82%
	Female	35%	18%
Not Employed/EI/ODSP		79%	73%
Completed High School?		21%	67%
Problem with Alcohol		47%	32%
Use illicit drugs (at least once a week)		15%	23%
Diagnosed with Mental Health Issues		44%	50%

Youth between the ages of 18 to 29 years of age, particularly those not in employment or education/training (NEET) are a priority group for LPRF. Youth between the ages of 18 to 29 made up 38% of the program compared to 62% who were 30 years of older. Youth at the RRP had lower likelihood of justice-involvement; however, they were slightly more likely to have experienced homelessness in the last 12 months prior to intake. Youth in the program were more likely to identify as male and Indigenous. In most other aspects, except for high school completion, youth had the same risks and challenges as the older age groups (see Table 16 below for breakdown).

Table 16: Age Comparison

		Age	
		18 – 29 (n=21)	30 and over (n=34)
Experienced Homelessness in the last 12 months?		53%	45%
Past Incarceration		43%	68%
Gender	Male	81%	65%
	Female	19%	35%
Ethnicity	Indigenous	76%	53%
	White	24%	47%
Not Employed/EI/ODSP		76%	76%
Completed High School?		24%	41%
Problem with Alcohol		43%	41%
Use illicit drugs (at least once a week)		19%	18%
Mental Health Diagnosis		48%	47%

The three priority groups of Local Poverty Strategy were well represented in the evaluation data. Findings suggest that females, Indigenous or First Nations and residents who are youth have unique challenges and barriers that increase their risk of homelessness and/or justice-involvement. The data, while limited, provides a snapshot of challenges faced by these priority groups in Thunder Bay, and reiterates the RRP's success in targeting and providing supports to the LRPF's priority groups.

5. REFLECTIONS & LOOKING AHEAD

5.1. Impact of COVID-19

As outlined in previous sections, there are several geographic, demographic, and social challenges faced by individuals residing in the city of Thunder Bay. These include, but are not limited to, a heightened risk for homelessness, limited access to resources, and substance use and mental health needs among vulnerable populations. At the onset of the pandemic and in the months following, Thunder Bay had minimal COVID-19 cases. However, in February 2021, the Thunder Bay District Health Unit declared a COVID-19 outbreak among those experiencing

homelessness or housing precarity within the city.[28] For vulnerable individuals experiencing homelessness as well as those exiting correctional facilities with limited access to housing and supports, the pandemic caused a deeper entrenchment of existing issues.

The following section will give a broad overview of the COVID-19 pandemic and the impacts it had on the Thunder Bay community, and consequently, the residents at the Residential Reintegration Program (RRP). It will provide an important lens in understanding the challenges encountered within the community and the impacts on the RRP program. As mentioned throughout this report, COVID-19 greatly impacted the evaluation. Data collection was on track to meet targets, however, the data collection strategy had to be revised due to COVID-19. To mitigate the reduction in data collection, the Evaluation Team relied on interviews with staff and residents, as well as a thorough analysis of residents' case notes.

5.1.1. Community

Thunder Bay is located in an isolated geographical location and is an urban centre to several Northern remote communities. Throughout most of 2020, Thunder Bay fared well with COVID-19 cases compared to more densely populated southern Ontario cities, maintaining a case load hovering well under one-hundred people. However, there was a COVID-19 outbreak starting in February 2021 among the homeless population, making Thunder Bay one of Canada's leading COVID-19 hotspots at the time, with over 650 cases within a 2-week period. In fact, Public Health Ontario stated that Thunder Bay had more than double the number of new cases than anywhere else in Ontario[29].

While COVID-19 may have been 'everywhere' in Thunder Bay, it was especially prevalent among the homeless population, within shelters, and in correctional facilities. In some ways, these populations were hit the hardest and experienced some of the greatest barriers to accessing adequate care. On February 10th, 2021, the city of Thunder Bay alerted media that an outbreak had occurred among those experiencing homelessness and in transitional housing. The outbreak among the homeless population in Thunder Bay was considered to have played a significant role in the staggering COVID-19 cases in the area. People experiencing homelessness are at much greater risk of exposure to COVID-19, as they often rely on congregate settings for services and housing. The policies and practices implemented in response to the pandemic to protect the community did not take into account the unique barriers faced by homeless populations[30]. In order to mitigate the spread of COVID-19, the Thunder Bay community put measures into place

[28] https://www.tbdhu.com/news/declaration-of-covid-19-outbreak-0
[29] Cousins, B. (Mar 9, 2021). "'COVID-19 is essentially everywhere': Thunder Bay, Ont. Is one of the leading hotspots in Canada", CTVNews. Retrieved from: https://www.ctvnews.ca/health/coronavirus/covid-19-is-essentially-everywhere-thunder-bay-ont-is-one-of-the-leading-hotspots-in-canada-1.5340753.
[30] Rally, M., Arcangeli, A., & Ercoli, L. (2021). Homelessness and COVID-19: Leaving no one behind. *Annals of Global Health, 87*(1), p.11.

including enhanced testing and surveillance, status of bed lists at shelters, and expansion of an isolation shelter[31].

In an attempt to reduce the spread of COVID-19, Ontario saw a rapid release of inmates from correctional facilities. Individuals faced challenges to follow health and safety guidelines as they may have been released from facilities without access to housing or a safe space to isolate, which led to accessing a shelter. Accessing shelter services increased individuals' risk of exposure, as shelters were viewed as 'super-spreaders' of COVID-19, given the close proximities residents had to one another as well as the transient lifestyle of those accessing shelters[32]. The freezing temperatures of Thunder Bay in winter months combined with the increased precarity facing individuals during numerous lockdowns, and shelters reaching capacity left many sleeping on the street[33].

Individuals released from correctional institutions are already faced with challenges in meeting their basic needs. They often have little to no social or emotional support in the community and limited access to food or housing. These individuals experienced challenges and confusion around COVID-19 guidelines and isolation protocols, as the new restrictions are similar to those that are enforced while incarcerated. The COVID-19 restrictions were an additional system for recently released individuals to navigate, making the re-entry process even more challenging.

Even more, food security was a significant issue among those released from correctional facilities and the homeless population in Thunder Bay. Staff at RRP explained that individuals were limited in what they were able to do, and their priorities shifted to having their basic needs met such as food and shelter.

"I find that food security is also a big issue right now because with everything that's going on, with limitations in what people are able to do for themselves. I think that a lot of people are putting their priority on basic needs instead of anything extra and above that. So that's what we're kind of focusing on at John Howard right now is just making sure that people's basic needs are met during the pandemic, and that their health is our top priority at this point."

- Staff, Interview

[31] Dunick, L. (Feb 10, 2021). "COVID outbreak declared in homeless population." Tbnewswatch. Retrieved from: https://www.tbnewswatch.com/local-news/covid-outbreak-declared-in-homeless-population-3371471.
[32] Iwundu, C. N., Santa Maria, D., & Hernandez, D. C. (2021). "Commentary: The invisible and forgotten: COVID-19 inequities among people experiencing homelessness." Family & Community Health, 44(2), p.108-109.
[33] Turner, L. (Feb 6, 2021). "Perfect storm of extreme cold, the shelter crisis and COVID-19 has people in Thunder Bay looking for solutions." CBC News. Retrieved from: https://www.cbc.ca/news/canada/thunder-bay/shelter-crisis-tbay-1.5903724.

5.1.2. The Residence

Programming

The COVID-19 pandemic severely impacted residents' access to programming as the residence went into lockdown. With the lockdown, residents were unable to congregate in common areas, recreational activities were put on pause, access to external agencies and supports were limited for the first few months, and the organization entered critical operations. These critical operations began with implementing the minimum number of staff required for basic operations of the residence. When the pandemic hit, there was a focus on prioritizing health, safety, and basic needs of residents, and staff had to work towards re-orienting how programming was delivered. Through interviews, both staff and clients discussed the impact that COVID-19 had on programming including recreational therapy activities, educational goals, life skills, social navigation, communication, access to services, and overall client progress.

Recreational activities drastically changed as a result of COVID-19. The delivery of these activities declined overall, and many activities that eventually did take place had to be virtual or socially distanced. Through interviews, residents discussed that they had not been able to do anything for a while; however, there were opportunities for cooking and crafts when the residence loosened lockdown restrictions. Staff also brought up concerns with lack of recreational opportunities during COVID-19 as it increased "dead space", mental health issues, and isolation for residents.

"It gives more empty space for the client, and I found that there's a lot more relapse and a lot more high turnovers and transitions because the dead space and the area that we are in. So, it's kind of a double whammy at this point."

- Staff, Interview

"I think that's really been the biggest shift, and obviously frequency I believe has been impacted. Given the barriers – not having as many staff on site as we did pre-pandemic, you know, it does – in some cases – limit, you know, just the frequency of opportunities, but we still try to make sure those opportunities do still exist and continue for our clients, you know – both those who are here and new clients coming into the program."

- Staff, Interview

"[With] COVID… people got really depressed – we had a lot of relapse with clients in the whole adjustment."

- Staff, Interview

To address the issues presented by COVID-19, recreational therapy restructured to provide socially distanced and virtual activities. The warmer weather in the summer months coincided with the loosening of restrictions in the province. This allowed the Recreational Therapist to be more present at the residence and take residents on outings where they could participate while maintaining a safe distance. This included hiking trips or activities in the JHS yard such as playing basketball; however, these activities were weather dependent and there were often no alternatives when an activity was rained out.

Other socially distanced activities involved life skills training through Facebook Live videos on the JHS-Thunder Bay Facebook page, which included the participation of residents in the community. Life skills training videos included weekly Wellbriety[34], *The Importance of Decluttering Your Space & Mind*, *Self-Care & the Outdoors*, a Halloween cooking event, and virtual bingo where residents could win prizes. Though these activities allowed residents to participate remotely and safely, access to technology for residents was limited.

Fortunately, for residents at RRP, there was access to the tablets within the residence, which provided some opportunities to participate in virtual activities. Through interviews, staff explained that the tablets were greatly beneficial over the pandemic as residents were able to be referred to access programs and workshops from external agencies remotely. Access to technology was both a benefit, but also a challenge for residents. In terms of communication, case notes revealed that one resident was provided with a phone for the duration of their isolation period upon moving into the residence. Conversely, however, the lack of access to technology for residents moving out at this time was a barrier to staff trying to reach out and support these individuals during the pandemic. Additionally, as the tablets were intended for educational use, they began to "be fried" from overuse. Staff also made mention that residents started to feel "zoomed out" accessing a virtual platform frequently.

"At the start of the pandemic there was a lot of uncertainty on how to approach things…. At the start of everything was virtual… They were really hit and miss, some clients find it really awkward being on screen, others were fine with it and would come out. But it would really depend on the program because sitting in a room with people hanging out and talking and doing an art project is fun when you're sitting around doing it with other people but on Zoom, they're like, 'can't I just do this in my room, why do I have to be on the screen to do this?'"

- Staff, Interview

"We're trying to get on technology, [but] everyone got Zoom'd out real quick, you know? So, COVID severely disrupted. Even though we gave arts and colouring supplies to clients – we made isolation kits, and so in that, it included some taxi vouchers, a colouring book, some crosswords,

[34] See http://www.sharingculture.info/wellbriety-movement.html

some Sudoku, masks, hand wipes – that kind of stuff just so people had something to do. So, COVID was atrocious. It was not good for [recreational therapy] at all."

- Staff, Interview

"They still have things, even when we have to social distance, they are doing what they can for everybody; they're doing their best. The residents are doing their best for what they can for us. We are understanding each other."

- Staff, Interview

JHS-Thunder Bay made use of the opportunity to connect with other agencies again when they could. Staff reached out to organizations in order to fill the gap in recreational activities at JHS by asking what they had available on their calendar. Near the beginning of the pandemic, staff were referring clients to places in the community such as the sports complex to go swimming or use the gym, however, with recurring lockdowns, it presented various difficulties. Staff explained through interviews that they would attempt to refer residents to different opportunities in the community; the resident would then commute by bus or on foot, only to find out that the service was cancelled, closed, or they were no longer accepting new clients.

The lack of recreational opportunities also reduced the secondary benefits that residents gained from participating in activities such as relationship building with others, including the Recreational Therapist. The Recreational Therapist explained that those participating in virtual activities most, both in the community and within the residence, were individuals that she had the opportunity to build rapport with before the pandemic. They discussed that residents that came into the residence during the pandemic were not afforded the face time with the Recreational Therapist that other residents had, making it harder to recruit new residents to activities, especially when programming was taking place virtually.

"Not being there full-time and not being at full capacity makes it really hard to say, 'Hey, come join; hey, come see me and lets hang out, that sounds fun'. Even being in the program room and lots of activities being on and people come downstairs to take a peek and think, 'maybe I'll join too'. It's a learning curve, that's for sure."

- Staff, Interview

Relationship building with other residents was also impacted greatly. The Recreational Therapist mentioned that, pre-COVID, residents would form friendships and build teamwork skills through recreational activities without even realizing it. However, with COVID-19, residents have not had the opportunity to connect in these ways.

"It's been harder to notice these things virtually through COVID as it's an hour on the screen and we're not really hanging out; just taking away the information we need and there's no post-conversation. There's no 'Hey you, come hang out with me!' – no, they have to stay in their rooms. I don't always know if there's finished products at the end of it… It's been harder to witness things. Those who participate I think it's purely out of boredom… Rather than all those benefits that come from in-person stuff. Curing boredom is good too though"

- Staff, Interview

"You know, it's unfortunate… and that's the part with Rec Therapy, it was connecting with people, it was going on outings, it was everything we are not allowed to do with COVID, right? And mixed with that, some life skills. So, Rec Therapy is that harm reduction approach – people are engaged, they're excited; getting people out into nature was a game changer… Just doing the arts and crafts is great and stuff, but the nature and the opportunity to participate in community events was like, just to see the shift in clients and the excitement and the increase in participation was amazing, so, it definitely had a positive effect. And see, that's the thing is that I wish this was longer because with those people who had transitioned out, we provided and created those opportunities of Recreational Therapy, and I just – I don't know if that's something that's actually feasible for individuals that, you know, they might have their own place, but they're completely maxed out with all their resources and whatnot just to get their basic needs. What is the opportunity to go for a hike? What is the opportunity to make it to the pow-wow in the mountain if not through John Howard or whatnot? So, that's the hard part, but Rec is great. It's amazing, it has really positive impact on people."

- Staff, Interview

In terms of the social navigation component, many challenges resulted from COVID-19 including the inability to allow past residents in the building for follow-ups, issues in accessing individuals with no technology, and challenges to assisting individuals to address their goals with most services shut down. The Social Navigator explained that her day-to-day involved an outreach component where she would drive around Thunder Bay to look for past residents to provide them with resources, connect them to any available services, and check-in on them.

"It's been a lot of surviving through the adversity that's there, but it has affected the clientele – you can see with the abilities to interact with us, the abilities to do the interviews with me – the 6-month, the 12-month follow-up because we are masked up, we don't have access to the building… they can't come in and sit in the interview room with me. We have had a couple clients pass away…. we have had a couple of my Social Nav clients pass away or overdose. So, we're kind of dealing with those imbalances, too, so it's kind of in a lot of chaos that it's thrown us into, but overall, the interactions with clients have differed really substantially because we can't have them come into the building, nobody really has access to phones, and then other services are essentially shut down. So, John Howard is still running in similar to what it was prior to the

pandemic, but more locked down. Other services have completely shut down – no access whatsoever."

- Staff, Interview

"I essentially do an outreach component… I'll drive around and look for our clientele… then they finally do get some access to services, but a lot of clients right now, if they are able to access phones through other agencies or other outreach workers, I'll have them do that or I'll have them come to my window and even do the interview through the window. It's not ideal, but it's still a face-to-face interaction. Some of them though – because the CERB payments actually came out, too, some of them did get increases in the money that they had coming in so some did get phones. For limited times, there were issues with that going on, too, but we have been doing mostly via telephone for the ones that I have been able to find."

- Staff, Interview

"With COVID, it's been a lot harder – I've seen people struggle a lot more and people who were doing amazing pre-COVID participating in everything and anything and getting everything in line I've seen those little slips and falls and the backtracks and what not. And I've seen a few people on the way who were like come on you were so close so close and I do wonder had COVID had not happened would that not have made the difference. I don't know what the ratio or percentage is but there are certainly community members that I'm still in touch with who are doing pretty decent and still independent and there are others who have backtracked. All of us absolutely do everything we can to ensure that successful transition and to make their stay at John Howard a lot easier. COVID has made it harder for sure"

- Staff, Interview

COVID-19 also affected the stability of residents within the program and resulted in a large turnover rate for residents.

"Before, it was much easier to manage who was actually participating in the program because there was more stability, and I know that stability is a big issue with COVID, with like, you're regular Joe-shmoe, and especially the clients that we deal with because they're so transient… before it was much easier to meet with them regularly, get them to come and connect, get them to come talk to us about forms or participating in anything extra on top of what they're already doing. So, now I'm finding that a lot of the people that we're getting into the building are very, very quick turnovers where they're coming in, they have no place to go, and we get them connected with our Social Nav, and she will transition them out. So, sometimes we have people move in and move out before I can even get like, their consent for the program which has made it difficult, but I understand. I'm not going to tell someone to move out so that we can do the program."

- Staff, Interview

As mentioned, COVID-19 presented challenges in communicating with and supporting residents. With the usage of the tablets decreasing, it became even more difficult to communicate with residents when staff were not in the building. This became even more challenging as residents would often approach the first staff member that they would see when they had a question, however, staff would not always have the answers they wanted or needed. This would turn into a broken chain of communication between staff who would have to reach out to another staff member to answer the question presented by the resident, and then have to relay back the information. These challenges became easier when staff were allowed to go into the residence more frequently and interact with residents face-to-face.

"Now that I'm in the building, they're much more comfortable just coming to me and be like, "hey, what's my rent?" or like, "what do I do about this?", and so, I think that it's just made it easier and again, it goes back to our clients being so transient that when they want an answer, they need that answer when they ask or else they're probably not going to get it because they're running around all day, so just being here to give them what they need."

- Staff, Interview

Residents of the Residential Reintegration Program

Residents experienced isolation from family, friends, their community, culture, legal representation, and with their daily life and routines. The COVID-19 pandemic also presented several instances of isolation, particularly for those residents who were coming out of correctional institutions.

Residents discussed through interviews that COVID-19 has made it hard to communicate and stay connected with family and friends. One resident discussed not having many friendships and having only an elderly family member that they could rely on, adding that living with this individual was the only place they could stay outside of RRP. Due to COVID, however, this resident was unable to visit with their family member for safety reasons. Another resident discussed the impact that COVID-19 has had on maintaining connections with family. They mentioned that they just wanted to be able to talk to someone from home, but that they were limited in doing so as a result of the pandemic and lockdowns.

In terms of friends, one resident shared that they developed many friendships through AA and the RRP, however, because of COVID-19, they have not been able to maintain these relationships. When the pandemic hit, many individuals were confined to their own "bubbles" and residents with physical health complications were required to take extra precautions when socializing with others. This resident, in particular, mentioned that they had a compromised immune system that required them to isolate and avoid others for their own safety. The Social Navigator would check-in with this resident often to provide supplies and connect them to remote services.

Other residents discussed being isolated from their culture and in the community more generally. One resident expressed the desire to learn from elders during this time but explained that COVID-19 has made it impossible to connect in-person, and that online teachings were not the same. Another resident explained the experience of quarantining within a correctional institution as well as in the community. With outbreaks in correctional facilities, individuals were distanced to prevent the spread of COVID-19. This resident explained that, while in an institution, they were required to spend months in solitary confinement. After release, mandatory quarantines were implemented in community housing such as shelters, hotel programs, and JHS-Thunder Bay. This resident explained that the experience of various instances of isolation has been detrimental to their mental well-being and compared the experience of quarantining in the community to solitary confinement.

In terms of daily routines and living in the residence during a pandemic, residents explained that they experienced a lot more "dead space", were unable to see friends within the building, and had concerns about their own safety from others. When asked about their day-to-day activities since the onset of COVID-19, residents explained that they do not have much to do to fill their time; one stated they stay inside and watch TV, for example, while another has coffee and "that's about it". With a strict lockdown put in place in the residence, friendships that were built among residents were difficult to maintain while abiding by the new restrictions. Some residents explained the experience as follows:

"Everybody stays in their room. You can't leave your room without a mask; there's only 2 people in the common room and they need to be separated. There's no people congregating together without a mask; it's very cautious here."

- Resident – Cohort 3, Interview

"We can't even sit together at lunch outside. We gotta be like 6-7 feet away from everyone. [It] made it hard."

- Resident – Cohort 3, Interview

In terms of safety, there were many instances where residents struggled to comply with COVID-19 health and safety guidelines. Case notes revealed that residents would enter common rooms without proper Personal Protective Equipment (PPE) on; some residents would comply after being told to put on a mask, for example, while others were reluctant or refused to comply. Two residents had more than five instances recorded in their case notes where they would not wear proper PPE in the common areas and were frustrated by the guidelines. Additionally, instances were recorded where residents would not be social distancing in common areas. This was of particular concern as case notes revealed that there were residents that tested positive for COVID-19 and were required to isolate. Residents did present concerns about other residents who presented any symptoms (e.g., coughing, sneezing) which resulted in maintaining more distance

from others and increased time spent in isolation. One resident did explain, however, that living at RRP during the pandemic was safer than living in a shelter.

"I pretty much came here with nothing… I went to isolation cause of COVID, and then I came here because I was pretty much homeless, and I'd rather be here than the shelter."

- Resident – Cohort 3, Interview

Residents experienced barriers to reaching their housing goals as a result of COVID-19. For a period of time, residents were unable to view housing units in-person as it was not considered an essential service in Ontario at the time. Conversely, however, COVID-19 did present some opportunities for those that were homeless. One resident explains:

"[I've been here] since December, and that's about when the second wave of the COVID hit. I was homeless and I had no place to go. Someone had told me about the John Howard previous years before, and I wasn't sure if it was true. So, when the second wave of the COVID hit I decided to try it out. And that is when I found out they do accept people with records and coming out of jail, because I didn't have one."

- Resident – Cohort 3, Interview

COVID-19 severely impacted residents achieving their goals as it relates to education and employment. In terms of education, residents discussed working towards their education before the pandemic, however, when educational services went virtual, it became too much. One resident explained that being on platforms such as Zoom began to wear them out and they lost interest in continuing their education, as a result. For those looking to obtain employment, the biggest challenge was that most businesses were shut down due to COVID-19. Residents that were employed before the pandemic were also impacted as they either lost their job as a result of the lockdown or their employment was put on hold. Additionally, this impacted individuals' volunteer opportunities, and one resident mentioned being reluctant to continue volunteering once the lockdown measures were lifted.

An additional challenge presented by COVID-19 was the opioid crisis and the likelihood of breaching conditions during the pandemic. Staff explained:

"The pandemic paired with an opioid crisis in town has been just devastating. Especially even for my clients who aren't living at the facility because most of the clients I have that are, essentially the outreach clients, they're street, and they're either living on the streets or living in very unsafe components, so that's where it's really a struggle with what we're encountering, but I think having more options for the clients could better provide more supports to keep them engaged because

we had people who were just hanging around yesterday and I'm like, COVID policies – I can't have you guys sitting in the hallway chatting with me because I also need to do a little bit of work as I'm in the hub."

- Staff, Interview

"I think just more engagement within that part just for boredom because we know – it's been evidence-based that boredom and lack of supports thus leads to further decline. And really, that's something I've really seen with the breach rates that have gone on in the facility. We have had higher breach rates within bail clientele. There are changes to that though because we have had all the transition from Bail Program Case Managers too because we previously had another girl that had taken over the position when I had been transferred to Social Nav, and then she left, and then now we have a new person in. So, those kind of like – changes really affect clients, but I think if we were to have a bit more structure on programs that might give them something to adhere to for a routine at least."

- Staff, Interview

"I have noticed that we have had more breaches during the pandemic and just a less engagement from clients overall, but it's also – you can't – they don't see us without our masks, they only see me for Wednesdays and maybe Fridays if I'm in because usually I'm driving around handing out Naloxone or stuff like that. So, there is – I've seen with the bail program, it has been more difficult as of currently."

- Staff, Interview

5.2. Challenges

This section presents the challenges experienced at RRP that were not a result of the COVID-19 pandemic. The challenges at RRP were related to the complex needs of the residents as well as the barriers within the residence and programming. Challenges were found primarily through case notes, and interviews with both staff and residents.

5.2.1. Complex Resident Needs

One of the biggest challenges related to the program was the limited resources to address resident needs as they were too complex to be adequately addressed by the program. These needs included mental health, substance use and addictions, toxic relationships, isolation, hesitancy and reluctance to accessing supports, and residents struggling to address their own basic needs.

Mental Health

The case notes and interviews revealed that many residents had various mental health needs including severe anxiety, paranoia, schizophrenia, depression, and suicidal ideation. Underlying almost all case notes was the experience of trauma as well as post-traumatic stress disorder (PTSD). Past trauma acted as a trigger in several instances exacerbating feelings of anxiety and presenting difficulties with regulating one's own emotions. Staff were exceptional in addressing mental health situations that occurred; however, these needs were often too high for the program to adequately address long-term.

Residents that joined RRP had a varying level of needs, and the most common mental health needs were anxiety, depression, and trauma which were interwoven throughout the challenges experienced. In terms of anxiety, residents felt anxious in attending appointments, connecting with services, and expressed fears about being kicked out of the residence for, often, minor occurrences. Trauma was brought up in many ways by residents including a history of physical and sexual assault, losing friends and family members to overdoses, physical and emotional abuse from family members and relationships, traumatic experiences from being incarcerated, and childhood trauma. This trauma manifested as triggers for residents who expressed negative memories being brought back, being fearful of leaving the building, and not being able to regulate their emotions. This led to residents expressing anger and frustration through use of profanities and yelling at staff at RRP.

Residents also experienced loneliness, guilt, and discrimination that held them back when addressing their needs. Some residents discussed that they felt confined while living in the residence, and that they missed their life outside of the building. Others expressed guilt in terms of being a parent with some reporting that they wished they had been a better role model, and others feeling regret for having their children taken away. Further, one resident explained through the interviews that they faced discrimination from members of the community, and as a result, they stopped accessing some services such as pursuing an education.

Substance Use & Addictions

Residents struggled to maintain sobriety due to factors inside and outside of the residence. Being around other individuals in the residence that had substance use issues acted as a trigger for residents who were working towards sobriety. Outside of the residence, residents would fall back into addictions when they would get involved with individuals from their past who were using substances. When residents returned to the residence under the influence, they would often not be allowed to enter the residence as it went against the rules of residency. Moreover, residents would breach rules of residency within the residence through the use and possession of drug paraphernalia. Additionally, case notes revealed residents receiving program warnings for being caught with drug paraphernalia and/or were smoking inside their rooms.

Toxic Family or Peer Group

As mentioned above, residents had toxic relationships with individuals outside of the residence. These relationships included family, current partners, ex-partners, and individuals that contributed to their criminal justice involvement. The case notes revealed many narratives of residents who would be excelling in RRP. However, an incidence with a family member returning or contacting them, for example, would de-rail the progress they were making. For some residents, interpersonal relationships and familial stressors were often major triggers for their substance use. Relationships with current or past partners, in particular, were especially triggering as residents were experiencing instances of domestic violence in the form of emotional, mental, and physical abuse. Moreover, in terms of criminal justice involvement, one resident explained that relationships they had with certain individuals put them in toxic situations leading to their criminal charges.

"Getting away from all the drug people... I realized that if you have toxic people around you, you don't have to be using drugs to be in a toxic situation… what I was looking for was a place to basically get away… I just walked away from everything. They allowed me to do that here. Which is good for me… I got lost. I just made bad decisions because I wasn't thinking of what I needed to be thinking about. And they gave me a home… yeah, the goal of getting my life back."

- Resident, Cohort 3, Interview

Isolation

Though some residents enjoyed the company of others and building relationship in the residence, others preferred to keep to themselves which resulted in them being isolated. Resident interviews revealed that, for some, isolation was related to a lack of trust in others from their past experiences of incarceration.

"No, I have no interest in being around people… I don't wanna be around people. Being around people makes me feel uncomfortable. I don't enjoy the company of another person, I don't wanna be around people… I think, like, people in my life don't even know who I am."

- Resident, Cohort 3, Interview

Hesitancy & Resistance to Accessing Supports

Through case notes and interviews, residents explained that they were hesitant or reluctant to access supports provided to them. For example, some residents stated that they were not ready to access certain services such as counselling, while others simply avoided counselling altogether. Interestingly, some residents explained that they did not want to access services as they believed others needed it more than they did.

"[The resident stated that they] had more than some of the residents here."

- Resident, Cohort 1, Case Notes

"I don't want to take the counselling spot from someone who needs it."

- Resident, Cohort 1, Case Notes

Other residents expressed concerns around accessing mental health supports as they were worried about confidentiality. Residents also had anxiety that presented itself in situations such as attempting to register and return to school as they believed that they had a lack of experience, and that it would not be the right fit for them.

"I don't really know how to do anything. I am just really inexperienced with everything, and because of that, I am reluctant. I am a procrastinator, it's pretty sad."

- Resident, Cohort 3, Interview

"I do have good intentions, I want to do stuff, but at the same time, I just have something that pulls me back – anxiety – keeps me from doing stuff. I have to fight it, I have to fight everything, I have to go against who I am to even accomplish anything. It's tough. I would sweat, having to meet new people. That kind of thing would panic me to death. I can't do that; I don't want to do that. So, I actively avoid situations like that."

- Resident, Cohort 3, Interview

Residents also mentioned that, when accessing supports, they would need to focus on one goal at a time as it would overwhelm them to access multiple supports at once. For example, residents would want to address their mental health before thinking about finding an apartment or would have to find employment before thinking about housing.

Addressing Basic Needs

Some residents showed many challenges to addressing their basic needs such as taking care of themselves. Case notes revealed many instances where residents would not clean up after themselves such as not cleaning dishes after using them or not cleaning communal spaces. As well, not cleaning their own room was reported several times, and residents would receive program warnings as a result during room checks. Some residents also struggled to eat properly and/or nutritiously. Case notes revealed residents not consuming enough water or nutrients, which in some cases, led to physical health implications.

5.2.2. Programming Challenges

Rules of Residency

As part of the residence, residents were required to follow the rules of residency. The case notes revealed several instances where residents struggled to abide by these rules and would often receive program warnings as well as evictions for breaching the rules. As mentioned earlier, substance use and possession of drug paraphernalia often resulted in program warnings for breaching the rules of residency. In addition, residents received program warnings most commonly for not coming into the residence at curfew, with over 20 instances recorded among six residents. Other rules of residency that were frequently breached include stealing items from the communal spaces, failure to reside in the residence, and conflicts with other residents including physical altercations. Depending on the frequency of program warnings or the severity, residents also received a program suspension which meant that they would be evicted from the residence.

Breaches

As mentioned in earlier sections, over 60% of the residents at RRP were a part of the BVSP. Case notes revealed several instances where residents would be breached through the program, with more than ten residents leaving as a result of breached conditions. Some ways in which individuals would be breached was through substance use, and program warnings leading to being evicted from the residence, meaning the resident would breach for failing to reside at that address.

Recreational Therapy

Residents faced challenges to participating in the recreational therapy activities such as physical barriers, scheduling conflicts, and lack of programming. Several residents shared that their physical health complications made them incapable of participating in the activities such as long walks or hikes, both of which were common activities in recreational therapy. Alternatives to physical activities were provided and residents were able to provide input, however, residents did not always enjoy the alternative options and were unsure of what activities they would want.

"No, I didn't do any of them... because I need a knee replacement and I have arthritis really bad, so I don't really do a whole lot. I walk but I do that by myself. [*if they were more inclusive for you, would you have attended?*] Well, possibly yes, but I really – I'm limited in my physical ability. So, they, they don't really search out any kind of physical activity or social activity. [*I heard there was a movie night - Did you attend any of those?]* No, they had a craft works and some other things there but no I didn't attend them."

- Resident, Cohort 2, Interview

"Yeah, but they do like other stuff like crafts like beading, making earrings, painting, stuff like that. Different things for different people. They ask us about our input on what we might like to do. I like to read, I watch movies. Can't really run around and jog."

- Resident, Cohort 3, Interview

Another barrier to recreational therapy activities was the timing of when it was scheduled, both in terms of the time of day and the season. Interviews with staff and residents revealed that residents were unable to attend activities due to conflicting schedules. Some residents had other obligations during the day such as court appearances, employment, or volunteering, and the activities were not offered in the evenings. As well, some residents would not be awake during the times that activities were offered, and in some cases, those activities were only offered once. Further, there were more recreational activities recorded in the summer months compared to the winter months, where residents were more likely to be isolated indoors.

Relationships with Others

The case notes and interviews revealed a number of conflicts between residents. These conflicts impacted programming for others and were also triggering for some. During programming, some residents' behaviour would be distracting or disturbing to others which negatively affected their experience during the activity. As well, residents found that they were triggered when other residents would discuss substance use in front of them. A few instances were also recorded of verbal or physical altercations between residents.

Staff Turnover

The RRP experienced constant staff turnover, particularly throughout the pandemic, as the residence was put under critical operations. Staff began their new roles quickly to focus on the needs of residents. Due to the restrictions with lockdown, it became difficult for residents and staff to build rapport.

5.2.3. Evaluation Challenges

As discussed throughout the report, COVID-19 was the biggest challenge to the evaluation. With the onset of the pandemic, all data collection activities were put on pause, and the Evaluation Team had to revise the data collection strategy while also ensuring the safety of program staff and residents. As a result of COVID-19, the evaluation strategy changed from, "*how well is the program working?"* to *"how well did the program adjust?*" The following section presents challenges experienced through the evaluation that were not a result of the COVID-19, however,

these may have been exacerbated by the pandemic. The challenges to the evaluation were primarily related to the evaluation plan, and data collection tools and processes.

Lack of Qualitative Measures

The evaluation strategy that was implemented for the program faced many barriers and challenges. First, the evaluation strategy relied mostly on quantitative measures which failed to capture rich qualitative data which could have provided context on the experiences of residents in terms of various issues, challenges, and barriers. For instance, the *Social Navigator Tracking* form captured whether residents were housed and/or re-housed after moving out, and the type and frequency of contact with residents. However, this form failed to capture the qualitative pieces surrounding the multi-faceted role of the Social Navigator. The Evaluation Team found through interviews with residents and staff, as well as case notes, that the Social Navigator's work went beyond housing and navigation of supports and services. The Social Navigator was often the contact at hospitals for residents and became a constant in residents' lives. Further, throughout the pandemic, the Social Navigator began an outreach component which involved driving around the community to find previous residents and provide them with any support needed. The quantitative focus of the *Social Navigator Tracking* form fell short of capturing these unique contacts which ultimately did not provide an accurate depiction of the Social Navigator's role.

Number & Irrelevance of Data Collection Tools

The evaluation strategy included a large set of tools and instruments to collect data from various components of the program. However, many of the instruments that were designed did not collect appropriate information and program staff did not find them to be relevant to the activities performed. For example, both the *Recreational Therapy Activities Tracking* form and the *Social Navigator Tracking* form were brought to the attention of the Evaluation Team as it did not accurately reflect the work that was being completed with residents. As a result, the Evaluation Team made several revisions to the tools to ensure that it was more reflective of the activities, and that relevant data was being collected for the evaluation. Revising these tools resulted in delays in data collection, additional barriers for staff and the Evaluation Team, and having lower than anticipated completion rates for the tools. The revision of tools caused some confusion for program staff, and some did not know how to complete the new tools provided. As a result, tools were not completed accurately or as frequently. As a result, the data collected was inadequate to answer the outcome evaluation questions which resulted in the Evaluation Team incorporating the use of one-to-one interviews and focusing on qualitative data to address any gaps.

Frequency of Data Collection

The frequency with which some of the data collection tools were to be implemented was burdensome and confusing for program staff. For example, Case Managers contacted the Evaluation Team as the frequency with which the *Client Status Survey* was set to once a month. Case Managers explained that this was too much for residents as they would get overwhelmed and felt that there was too much paperwork. The *Client Status Survey* was changed to being collected once every three months, however, further challenges to response rates related to residents' reluctance to participate or engage. Another example relates to both the Recreational

Therapy and Social Navigator components. These roles required program staff spending their time focusing on residents in the community or within the residence. However, completing the required tools frequently was time-consuming for program staff, and they did not want this to take away too much time from residents.

Staff Turnover

As mentioned in the previous section, the RRP experienced staff turnover, especially during the pandemic, requiring new staff to be trained in the data collection tools. Prior to the pandemic, the Evaluation Team would meet with staff to onboard and train staff in the data collection tools. However, with restrictions imposed as a result of COVID-19, it became challenging to onboard new staff with adequate training on the evaluation tools. With JHS-Thunder Bay under critical operations, it became difficult to connect with staff as they were often providing one-to-one support within the residence or the community. As well, due to the pandemic, staff would begin their role at RRP immediately with little to no time for onboarding in the evaluation as the focus was on providing services and supports to residents.

Low Number of Evaluation Participants

With the onset of the pandemic, JHS-Thunder Bay went into lockdown for the health and safety of staff and residents. As a result, the intake process was put on pause and few residents were moving into the building at this time. This meant that fewer residents were able to consent to the evaluation and was a challenge that remained throughout the course of the program. When some lockdown measures were lifted, the Evaluation Team incentivized participation in one-to-one interviews with any eligible residents at RRP. Residents from Cohort 3, in particular, did not have any pre-post assessments or opportunities to complete most of the data collection tools as data collection was halted when they joined the program.

Need for Relevant Indigenous Tools

The evaluation strategy failed to incorporate relevant Indigenous tools, measures and methods while evaluating both the program's processes and outcomes while accounting for Indigenous perspectives and histories. This was particularly significant given the large proportion of RRP's residents and evaluation participants identifying as Indigenous or First Nations.

Data Collection of Program Staff

The evaluation strategy failed to include program staff as part of the formal data collection plan. All tools that were implemented for the evaluation were targeted to capture the experiences of residents or the perspectives of stakeholders, however, this did not provide the invaluable tool of hearing first-hand experiences from program staff. Though it was not set out in the initial plan, the Evaluation Team conducted informal interviews with program staff and asked about their perspectives of the program, and insights from program management on program operations. These interviews provided context to other tools that failed to accurately depict certain components of the RRP such as the Recreational Therapy and Social Navigator components.

5.3. Recommendations

5.3.1. Program (Service Delivery)

The programming of the RRP resulted in a number of challenges, as outlined in the section above, and lessons learned allowing the Evaluation Team to develop some recommendations for future service delivery. Though many of the program challenges were specific to the COVID-19 pandemic, other challenges identified were not related to the pandemic. We have outlined some steps to inform future service delivery. We do recognize that some of the recommendations outlined below would require substantial investment/funding, while others may not be feasible as COVID-19 continues to impact the services. The following section outlines five key recommendations to be considered by RRP and other similar programs with similar service delivery models.

1. Increase Number of Program Staff

Though staff did an exceptional job at attending to resident's needs, the challenges experienced by residents may be better addressed with more available staff. With the overwhelming number of residents affected by mental health issues, especially trauma, it may be beneficial to have more staff available to address mental health specifically. Additionally, as the recreational therapy component of the program was demonstrated to be crucial and the challenges related to recreational therapy activities related to the availability of services, it would be valuable to have more than one individual in this role.

Future service delivery of the RRP should invest in hiring additional program staff to attend to the varying needs of residents, including mental health, recreational therapy, and life skills training.

2. Expand Access to Support and Resources In-House

As mentioned in the challenges, residents expressed resistance and hesitancy when they were referred to services. Although the program provided a wide variety of supports and resources to residents through referrals, this did not guarantee that residents would connect with those services. Residents demonstrated experiences of trauma, anxiety, a lack of trusting others, and fear of leaving the residence for safety reasons. Individuals also expressed procrastination and a lack of motivation which would also act as barriers to accessing services outside of the residence. Though the program did offer resources in-house prior to the pandemic, it would benefit from expanding these in-house services and increasing the frequency with which they to place to encourage and motivate residents to participate.

Future service delivery of the RRP should expand the support and resources in-house based on the immediate needs of residents, such as trauma-specific counselling, addiction supports, and life skills training to address basic needs.

3. Expand and Improve Access to Recreational Therapy Activities

As addressed in the challenges, recreational therapy activities did not always engage residents in programming. For various reasons, from physical barriers to scheduling conflicts, residents were unable to attend recreational therapy or were limited in the available options. Though residents were able to provide their ideas for activities, this was not well-known amongst the residents. In addition, with the level of anxiety revealed through *Case Notes* and interviews, residents are likely not reaching out and providing input in the types of activities that they would like to participate in. Further, the number of activities tended to decline in the winter months due to lack of access to outdoor activities. However, this time of the year presents more isolation and boredom as residents are indoors as opposed to outside during the summer months. An effort should be made to develop more activities that can be accessed indoors during these times, as well as for those who are physically unable to do outdoor activities more generally. In addition, since residents showed challenges with addressing their basic needs such as eating or cleaning up after themselves, the program should increase the focus on life-skills programming within recreational therapy.

Future service delivery of the RRP should expand and improve access to recreational therapy activities. Recreational therapy activities should include more accessible activities and find ways to engage with more residents. Additionally, a key focus should be towards increasing life-skills programming for residents to address their basic needs.

4. Expand the Reach of Programming to Relevant Groups

Though the program had various types of recreational therapy activities and life-skills programming, it did not have enough gender-specific or age-appropriate programming. Since many female residents came into the program with a history of domestic violence, it would be beneficial to have programming specific to females. Not only would it present the opportunity to provide trauma-informed programming specific for females, but it could offer a safe space where they could discuss their experiences without feeling triggered or uncomfortable by the presence of male residents. Additionally, it may be helpful to have programming specific to males where they may address their own needs in a safe and comfortable space. Some examples of programming would be discussions around mental health and substance use. Moreover, there should be age-appropriate programming. As the age of residents various across a wide range of age groups, it may be beneficial to have activities targeted for younger groups or older groups, for example.

Future service delivery of the RRP should incorporate gender-specific and age-appropriate programming to encourage participation in recreational therapy activities and life-skills programming.

5. Incorporate Peer Support Workers into Program

As mentioned, some residents came into the program and were isolated from others, kept to themselves, and did not participate in activities. Employing a previous or existing resident as a Peer Support Worker would be beneficial to residents, especially incoming residents, to encourage and motivate participation. Peer Support Workers are able to act as a confidant and develop rapport with residents. Residents may be more likely to get the most of the RRP program, such as attending recreational therapy activities, if they have the support and encouragement from a fellow peer, rather than a staff member. Peer Support Workers would also be able to provide support by connecting residents to the appropriate staff member for resources.

Future service delivery of the RRP should employ current or previous residents as Peer Support Workers to provide support to incoming residents and encourage participation in the program.

5.3.2. Future Evaluations

The evaluation of RRP resulted in a number of challenges, as outlined in the section above, and lessons learned allowing the Evaluation Team to develop concrete recommendations for future research. Many of the evaluation-specific challenges were specific to the COVID-19 pandemic. While it is difficult to make recommendations for unanticipated events, we have outlined some steps future researchers and evaluators can take to limit the impact of unforeseen events. The following section outlines seven key recommendations for future research and/or evaluation initiatives related to the RRP and other similar programs/services.

1. Develop Evaluation Training Resources

The evaluation of RRP included many data collection instruments and processes. Data was collected on various aspects of the program by the Evaluation Team, program staff and management. The program's evaluation called for training to be provided to staff at evaluation start, with annual refreshers. Like most community-based programs/services the RRP experienced constant staff turnover, particularly during the pandemic. With the restrictions imposed as a result of the pandemic it became difficult to onboard new staff and provide them adequate training on the evaluation instruments in a timely fashion.

Future evaluations should include robust resources in the form of guides and instructive videos on various aspects of the evaluation. These guides should include overview of the roles and responsibilities of each staff at the RRP as well as step by step instructions on how to complete various forms and instruments.

2. Implement Qualitative Tools at Evaluation Start

RRP's evaluation strategy included various data collection tools and instruments. Most of the tools included the collection of quantitative measures. Residents at the RRP had various issues, challenges and barriers based on their unique circumstances. In addition, unanticipated events such as COVID-19 pandemic resulted in new challenges and issues which the original data collection strategy did not account for. The pandemic also resulted in lower than anticipated engagement in the pre/post instruments. As a result, data available to the Evaluation Team was inadequate in answer key questions and drawing out outcome information to triangulate some of the findings.

The Evaluation Team was able to revise tools and administer qualitative interviews during the pandemic to supplement the data collection.

Future research on the RRP should emphasize qualitative data over quantitative and allow greater flexibility in collecting data using various methods to ensure key evaluation questions are answered.

3. Frequent and Formal Collection from Staff and Management

Program staff and management are key stakeholders in evaluation of any program. Program staff can provide a unique perspective on program processes and outcomes. In addition, program management are able to give insights in regard to program operations, challenges and opportunities. The RRP evaluation plan did not include staff as part of the formal data collection source. While informal conversations and meetings did take place regularly between staff, management and the Evaluation Team, a formalized process and interviews were not implemented until 2020. Data collected from staff interviews proved invaluable in addressing the gaps the evaluation strategy and triangulating the findings from the evaluation.

It is highly recommended that future research incorporates formalized and frequent surveys, interviews and focus groups to solicit responses from staff and program management.

4. Flexible and Relevant Data Collection Instruments

The RRP's evaluation strategy included large set tools and instruments to collect data from various components of the program. Due to the changing nature of the program and services such as Recreational Therapy and Social Navigator, many of the instruments originally designed did not collect the appropriate information and were not relevant to the activities performed by staff. In addition, staff at the RRP indicated that frequency of data collection for some tools resulted in challenges for both staff and residents.

The Evaluation Team had to make several revisions to the tools and data collection timelines to ensure adequate and relevant data was being collected. This resulted in delays in data collection and additional barriers for staff and the evaluation team.

Future research should ensure tools are relevant to the program and the evaluation design should implement multiple methods (e.g., participatory research, photo voice, etc.) to account for changing nature of services.

5. Incorporate Indigenous Specific Evaluation Tools and Methods

A large proportion of RRPs residents, and evaluation participants, identified as Indigenous or First Nations. The RRP evaluation strategy did not incorporate relevant Indigenous tools, measures and methods while evaluating the program's processes and outcomes while accounting for Indigenous perspectives and histories. In recent years, there has been significant progress made in the field of evaluation to develop evaluation methodologies that honour reconciliation and take into account the impacts of trauma and colonization.

Future research related to the RRP and similar programs that provide service to Indigenous Peoples should incorporate Indigenous tools, methods and perspective by developing tools and instruments that take into account Indigenous ways of life and experiences. In addition, future research would benefit from Indigenous perspectives, either as formal partners or advisors to guide the evaluation from the start.

6. Incorporate Standardized Attendance/Dosage Form Consolidate Data Collection

A major limitation of the data collection strategy was the large number of evaluation tools and instruments. The tools required input and completion by staff various staff depending on their specific roles and responsibilities. Staff reported difficulties in assessing what tool to complete and when. This resulted in some tools having lower than anticipated completion.

Future evaluation projects should opt for a single attendance/dosage form that collects information across several components of the program. The tool would also need to be flexible to collect

information based on the type of service provided. Having a single consolidated form would reduce confusion for staff and ensure consistent data collection across all program activities.

7. Increase Participant Engagement through Incentives and Participatory Methods

A major challenge for the program was the lower participation by residents in the evaluation. While participation was at anticipated target prior to the pandemic, COVID-19 created significant barriers to data collection. Even prior to the pandemic, the program had difficulties encouraging residents to complete all of the tools (particularly post-tests and client surveys). One of the ways to mitigate these challenges would be to adopt strategies to incorporate and encourage more residents to actively engage in the evaluation process.

Future research would benefit greatly from adopting participatory research method and providing regular incentives/honorariums for residents to increase engagement. When individuals feel genuinely involved and consulted on the direction of research can greatly increase engagement and interest.

6. CONCLUSION

The evaluation of the Residential Reintegration Program (RRP) at JHS-Thunder Bay was structured under a realist evaluation framework and aimed to contribute to Ontario's 10-year plan to end chronic homelessness by illuminating what works for youth, women, and Indigenous peoples leaving provincial correctional institutions. Through addressing the needs of individuals residing at RRP, their criminogenic risks, and by providing transitional housing, the goal of the RRP was to ultimately contribute to decreased homelessness in Thunder Bay. Overall, the program was successful in recruiting residents from the target population, with the majority identifying as Indigenous or First Nations, and seeking assistance and supports related to justice-involvement, mental health and substance use issues, education, and employment issues. Moreover, the RRP ensured a sizable portion of those who left the program were housed at exit.

What made the RRP especially unique was the Recreational Therapy and Social Navigator components. Despite limitations imposed by the pandemic, both components were successful in providing the necessary support to RRP residents. Overall, the Recreational Therapist engaged with 38 residents involved in the evaluation, with 330 recreational activities provided and 700 instances of participation. The recreational activities covered a wide range of different activities and provided residents with the opportunity to build pro-social relationships with others while learning valuable life skills. Furthermore, the Social Navigator was directly involved in successfully housing 16 residents in the community and connecting through follow-ups 169 times with previous residents. The Social Navigator component proved to be an invaluable resource for residents that went far beyond housing or community navigation.

The RRP also addressed a number of indicators noted in the Local Poverty Strategy including residents who were homeless, youth, Indigenous and First Nations, and female. Overall, the three priority groups were well represented in the evaluation data. The findings suggest that individuals from the aforementioned groups have unique challenges and barriers that increase their risk of homelessness and/or justice involvement that the RRP successfully addressed.

As mentioned throughout the entirety of the report, the COVID-19 pandemic had a tremendous impact on the RRP and residents, which exacerbated pre-existing challenges such as mental health, trauma, and isolation. Overall, the most significant challenge to the RRP was the complexity of residents' needs which spanned far beyond what could be addressed by the program, a sentiment that was echoed by program staff, stakeholders, and residents themselves.

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7.4. Materials Currently in Use by Program

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Appendix T: Intake Form

Appendix U: Resident Action Plan (RAP)

7.1. Evaluation Methodology

Appendix A: Process Evaluation Results Matrix

The Residential Reintegration Program (RRP) Process Evaluation Results Matrix		
Process Question	*Indicator*	*Data Source*
Resident Profile		
1. Did RRP accurately identify and deliver services to the target population?	• # individuals presenting to RRP • # eligible • % of eligible accepted • # on waiting list (on vacancy list or referred)	• Intake forms • Resident Tracking Sheet (IMS)
2. What were the demographic characteristics of the participants?	• % participants broken down by age, gender, ethnicity, marital status, educational level, and employment status.	• Intake forms
Program Services & Supports		
3. To what extent is the residence being utilized?	• # of beds occupied • # of serious occurrence reports (qualitative data)	• Resident Tracking Sheet (IMS) • Serious occurrence reports
4. Did residents receive access to housing and resources?	• % residents accessing food banks and clothing services. • % connected to Ontario Works (OW) and Ontario Disability Support Program (ODSP) for income/rent support • Referrals to counselling	• Client satisfaction form • Attendance forms (IMS)
5. To what extent did residents participate in activities/programming?	• # activities/programming attended by residents. • % attended that were completed	• Attendance forms (IMS)
6. To what extent did residents participate in recreational opportunities?	• # of recreational activities delivered • % of clients participating in activities • # activities participated in per client • Avg amount of time per week	• Attendance forms (IMS)

The Residential Reintegration Program (RRP) Process Evaluation Results Matrix		
Process Question	*Indicator*	*Data Source*
7. Number of goals that residents have in common with each other?	• Goals as indicated in RAPs	• RAP forms
8. Did residents engage in psychosocial programming as specified in their RAP?	• # of activities in which resident participated. • % overlap between RAP and life-skills programs participated in	• RAP forms • Attendance forms (IMS) • Case notes provide some details on the specific mental health services clients were referred to.
9. Did the Case Manager implement a client-centred approach appropriately?	• % of total at full, partial and limited/none compliance with fidelity checklist.	• Client-Centered fidelity checklist
10. Did the Social Navigator provide the intended services for participants exiting the program?	• # clients SN worked with • # of attendees in SN programming • # of referrals • # of follow-ups • # clients finding housing through SN • Client ratings	• Social Navigator tracking form • Client Satisfaction Survey • Case Notes provide plenty of detail on their activities with clients
11. Did the Recreational Therapist provide the intended services?	• # clients RT worked with • # of attendees in RT activities • Client ratings	• Recreational Therapist tracking form. • Client Satisfaction Survey
12. In what ways did COVID-19 impact residents' involvement in the program and access to programming and services?	• Client ratings • Staff ratings • # of recreational therapy activities • • % of clients participating in activities	• Client Interviews • Staff Interviews • Recreational Therapy Tracking (IMS) • Case Notes
Program Satisfaction-Resident		
13. Were residents satisfied with the intake process (including orientation and move-in)?	• Resident ratings	• Client satisfaction form

The Residential Reintegration Program (RRP) Process Evaluation Results Matrix		
Process Question	*Indicator*	*Data Source*
14. How satisfied were residents with the life skills programming?	• Resident satisfaction scores re psychosocial components	• Client Satisfaction Survey
15. How satisfied were residents with the recreational therapy activities?	• Client satisfaction scores re recreational therapy components	• Client Satisfaction Survey
16. What are residents' perception of the program? What worked/didn't work? What were facilitators/ barriers? What did they like best/least?	Qualitative themes in different domains for example: • How well are they coping? • Facilitators/Barriers? • Like most/least	• Client satisfaction survey • Client status survey
Program Satisfaction-Stakeholders		
17. How satisfied were community partners with the program overall?	• Item scores	• Partner Satisfaction Survey
18. How satisfied were community partners with the referral process?	• Item scores	• Partner Satisfaction Survey
19. Did RRP effectively engage partners in coordinating service delivery planning?	• Satisfaction scores	• Partner Satisfaction Survey
20. Did RRP increase partnerships/relationships with landlords?	• Item scores	• Partner Satisfaction Survey • Case Notes reveal some partnerships or transitions to private landlord

The Residential Reintegration Program (RRP) Process Evaluation Results Matrix		
Process Question	*Indicator*	*Data Source*
21. Did RRP increase formalized partnerships with other community agencies to deliver on-site services?	• Item scores	• Partner satisfaction survey
22. In what ways did COVID-19 impact community partners' involvement with RRP?	• Item scores • Staff ratings •	• Partner Satisfaction Survey • Staff interviews
Sustainability		
23. Does the program have a plan for sustainability?	• # of funders identified • # of funding applications submitted • # of successful funding application	• Staff interviews

Appendix B: Outcome Evaluation Results Matrix

The Residential Reintegration Program (RRP) Process Evaluation Results Matrix		
Outcome Question	Indicator	Data Source
Access Immediate Housing Supports		
1. Did residents maintain safe and permanent housing following their stay at RRP; and at follow-ups.	• # residents in permanent housing after RRP exit • Length of time in private housing	• Pre-Post assessment
Awareness of Needs & Services		
2. Did residents have an increased understanding and acceptance of their own needs and issues?	• Awareness and acceptance subscale	• Pre-Post assessment • Client Interviews
3. Did residents show increased awareness in how to obtain needed community assistance such as mental health, employment, and relationships guidance?	• Community service access confidence	• Pre-Post assessment • Client Interviews
Independent Living Skills		
4. Did residents show improved coping and life skills?	• Coping and life skills subscale	• Pre-Post assessment • Client status form
5. Did residents improve their ability for living independently?	• Coping and life skills living subscale	• Pre-Post assessment • Client Interviews
6. Did residents show improvement in self-efficacy, social support, and mental well-being?	• Coping and life skills living subscale subscale (pre-post) • Mental wellbeing subscale (SPIn)	• Pre-Post assessment

The Residential Reintegration Program (RRP) Process Evaluation Results Matrix		
Outcome Question	Indicator	Data Source
Protective Factors		
7. Did residents improve their awareness of the benefits of, and their motivation to participate in, recreational opportunities?	• Recreational subscale	• Pre-Post assessment • Client Interviews
8. Did residents find and maintain employment (other forms of sustainable income), for 6 months or more	• Employment status	• Pre-Post assessment
9. Did residents improve their educational status?	• Educational status	• Pre-Post assessment • Client Interviews
Criminogenic Risk		
10. Did residents reduce overall risk levels for criminal justice involvement?	• SPIn dynamic subscales	• SPIn assessment

Appendix C: Process & Outcome Finding Tables

Table 1: Chi-Square Comparisons Across Cohorts by Demographic Profile					
1a					
Age		Cohort			Total
		One	Two	Three	
18-24	#	11	3	0	14
	% within cohort	31.40%	21.40%	0.00%	25.50%
25-34	#	9	4	1	14
	% within cohort	25.70%	28.60%	16.70%	25.50%
35-44	#	5	4	0	9
	% within cohort	14.30%	28.60%	0.00%	16.40%
45-54	#	6	0	3	9
	% within cohort	17.10%	0.00%	50.00%	16.40%
55-64	#	3	2	0	5
	% within cohort	8.60%	14.30%	0.00%	9.10%
65+	#	1	1	2	4
	% within cohort	2.90%	7.10%	33.30%	7.30%
Total	#	35	14	6	55
	% within cohort	100%	100%	100%	100%
x^2 (10, n=55) =18.658, $p < .05$*					
1b					
Gender		Cohort			Total
		One	Two	Three	
Female	#	12	1	3	16
	% within cohort	34.30%	7.10%	42.90%	28.60%
Male	#	23	13	4	40
	% within cohort	65.70%	92.90%	57.10%	71.40%
Total	#	35	14	7	56
	% within cohort	100%	100%	100%	100%
x^2 (2, n=56) =4.410, p= .110					
1c					
Indigenous		Cohort			Total
		One	Two	Three	
Yes	#	23	7	4	34
	% within cohort	65.70%	50.00%	57.10%	60.70%
No	#	12	7	3	22
	% within cohort	34.30%	50.00%	42.90%	39.30%
Total	#	35	14	7	56
	% within cohort	100%	100%	100%	100%
x^2 (2, n=56) =1.078, p= .583					

Table 2: Chi-Square Comparisons Across Cohorts by Violent History					
2a					
Recent Violent Behaviour		Cohort			Total
		One	Two	Three	
Yes	#	12	3	1	16
	% within cohort	34.30%	21.40%	14.30%	28.60%
No	#	23	11	6	40
	% within cohort	65.70%	78.60%	85.70%	71.40%
Total	#	35	14	7	56
	% within cohort	100.00%	100.00%	100.00%	100.00 %
x^2 (2, n=56) =1.610, p = .447					
2b					
History of Physical Fights		Cohort			Total
		One	Two	Three	
Yes	#	9	3	0	12
	% within cohort	25.70%	21.40%	0%	21.40%
No	#	26	11	7	44
	% within cohort	74.30%	78.60%	100%	78.60%
Total	#	35	14	7	56
	% within cohort	100%	100%	100%	100%
x^2 (2, n=56) =2.291, p= .318					

Table 3: Chi-Square Comparisons Across Cohorts by Education & Employment					
3a					
Education		Cohort			Total
		One	Two	Three	
University	#	0	1	0	1
	% within cohort	0%	7.10%	0%	1.90%
College	#	0	0	1	1
	% within cohort	0%	0%	14.30%	1.90%
College / Trade	#	2	4	0	6
	% within cohort	6.10%	28.60%	0%	11.10%
Graduated High School	#	8	2	3	13
	% within cohort	24.20%	14.30%	42.90%	24.10%
Some High School	#	20	6	1	27
	% within cohort	60.60%	42.90%	14.30%	50.00%
Elementary	#	2	0	2	4
	% within cohort	6.10%	0.00%	28.60%	7.40%
Other	#	1	1	0	2
	% within cohort	3.00%	7.10%	0%	3.70%
Total	#	33	14	7	54

% within cohort	100%	100%	100%	100%
x^2 (12, n=54) =25.300, p < .05*				
3b				

Employment		Cohort			Total
		One	Two	Three	
Full-time	#	3	1	0	4
	% within cohort	8.60%	8.30%	0.00%	7.40%
Part-time	#	6	2	0	8
	% within cohort	17.10%	16.70%	0.00%	14.80%
Not Employed	#	26	9	7	42
	% within cohort	74.30%	75.00%	100.00%	77.80%
Total	#	35	12	7	54
	% within cohort	100%	100%	100%	100%
x^2 (4, n=54) =2.301, p= .681					

Table 4: Chi-Square Comparisons Across Cohorts by Frequency of Substance "x" At Least Once a Week

4a

Alcohol or cannabis at least once a week		Cohort			Total
		One	Two	Three	
Yes	#	31	10	7	48
	% within cohort	88.60%	71.40%	100%	85.70%
No	#	4	4	0	8
	% within cohort	11.40%	28.60%	0%	14.30%
Total	#	35	14	7	56
	% within cohort	100%	100%	100%	100%
x^2 (2, n=56) =3.733, p = .155					

4b

Illicit drugs (e.g., cocaine, crack, or heroine) at least once a week		Cohort			Total
		One	Two	Three	
Yes	#	17	10	5	32
	% within cohort	48.60%	71.40%	71.40%	57.10%
No	#	18	4	2	24
	% within cohort	51.40%	28.60%	28.60%	42.90%
Total	#	35	14	7	56
	% within cohort	100%	100%	100%	100%
x^2 (2, n=55) =2.800, p = .247					

Table 5: Chi-Square Comparisons Across Cohorts with Mental & Physical Health Issues at Intake					
5a					
Mental Health Concern		Cohort			Total
		One	Two	Three	
Yes	#	12	6	1	19
	% within cohort	34.30%	42.90%	14.30%	33.90%
No	#	23	8	6	37
	% within cohort	65.70%	57.10%	85.70%	66.10%
Total	#	35	14	7	56
	% within cohort	100%	100%	100%	100%
x^2 (2, n=56) =1.705, p = .426					
5b					
Physical Health Concern		Cohort			Total
		One	Two	Three	
Yes	#	9	6	3	18
	% within cohort	25.70%	42.90%	42.90%	32.10%
No	#	26	8	4	38
	% within cohort	74.30%	57.10%	57.10%	67.90%
Total	#	35	14	7	56
	% within cohort	100%	100%	100%	100%
x^2 (2, n=56) =1.768, p = .413					

Table 6: Chi-Square Comparisons Across Cohorts on Past Homelessness					
6a					
Experienced homelessness in the past year?		Cohort			Total
		One	Two	Three	
Yes	#	14	7	4	25
	% within cohort	41.20%	58.30%	57.10%	47.20%
No	#	20	5	3	28
	% within cohort	58.80%	41.70%	42.90%	52.80%
Total	#	34	12	7	53
	% within cohort	100%	100%	100%	100%
x^2 (2, n=53) =1.370, p = .504					
6b					
If yes in table 11a, how many times in the past year?		Cohort			Total
		One	Two	Three	
Three times or more	#	5	0	1	6
	% within cohort	35.70%	0%	25.00%	24.00%
Twice	#	4	1	0	5

	% within cohort	28.60%	14.30%	0%	20.00%
Once	#	5	6	3	14
	% within cohort	35.70%	85.70%	75.00%	56.00%
Total	#	14	7	4	25
	% within cohort	100%	100%	100%	100%
x^2 (4, n=25) =6.301, p = .178					
6c					
If yes in table 11a, how long homeless most recently?		Cohort			Total
		One	Two	Three	
9 months or longer	#	2	1	2	5
	% within cohort	14.30%	14.30%	50.00%	20.00%
5 to 8 months	#	1	0	1	2
	% within cohort	7.10%	0%	25.00%	8.00%
1 to 4 months	#	5	1	0	6
	% within cohort	35.70%	14.30%	0%	24.00%
Less than 1 month	#	6	5	1	12
	% within cohort	42.90%	71.40%	25.00%	48.00%
Total	#	14	7	4	25
	% within cohort	100%	100%	100%	100%
x^2 (6, n=25) =7.515, p = .276					

7.2. Satisfaction Survey Results

Introduction

This report presents the cumulative results of two surveys designed and administered by the Centre of Research & Policy (the Centre) at the John Howard Society of Ontario (JHSO) as part of the evaluation of the Residential Reintegration Program (RRP), delivered by the John Howard Society of Thunder Bay & District (JHS-Thunder Bay) and funded by the Ontario Trillium Foundation's Local Poverty Reduction Fund (LPRF). The RRP operates a 47-unit residential facility that provides transitional housing to local men and women, aged 18 and older, who have experienced some sort of involvement with the criminal justice system and are either homeless or at a greater risk of becoming homeless. Participants in the RRP consists of bail clients and those attempting to reintegrate into society post incarceration. The main objective of the RRP is to minimize homelessness and reduce the risks of recidivism and involvement with the criminal justice system.

This survey report discusses the results from two surveys: *Client Satisfaction Survey* and the *Program Stakeholder Satisfaction Survey*, which were administered to clients and stakeholders involved with the RRP. The purpose of administering these surveys was to gain insights on client and stakeholders' perspectives of the program. The data collected from the surveys will be used to inform the final Evaluation Report for the program.

Survey Design and Methodology

The *Client Satisfaction Survey* was distributed upon program exit by the Data Entry Assistant. Those who completed the survey include individuals residing at JHS-Thunder Bay's RRP. The survey included thirty-six (36) open ended and closed ended questions assessing several aspects of the client's experiences throughout the program such as impressions of program staff, aspects of the program that were helpful or unhelpful, perception of changes in several aspects of daily life, and suggestions on how to improve the program.

The *Program Stakeholder Satisfaction Survey* was distributed by the Evaluation Team at the Centre via email to externa stakeholders that were identified by RRP staff. The email contained a link to the survey and instructions for completing the survey. The survey contains twenty-two (22) open ended and closed ended questions which aim to gain insights on stakeholders' overall satisfaction with the RRP. Respondents are asked to rate their level of engagement with the program and staff as well as the level of support from the organization. They were also asked to rate the structure of the RRP program in terms of efficiency, competency, and approachability. Partners were asked to comment on the most and least preferred aspects of working with the program and provide suggestions for improvement.

All survey data collected for the RRP was entered into the online survey management system, Alchemer, between March 2019 to May 2021. The data from the surveys was securely stored on Alchemer and downloaded by the Evaluation Team at JHSO in the form of an Excel spreadsheet. The survey consisted of primarily closed-ended questions, supplemented by open-ended questions, providing an outlet to further explain responses to closed-ended questions. This project has received approved from the John Howard Society of Ontario's Research Ethics Board (REB).

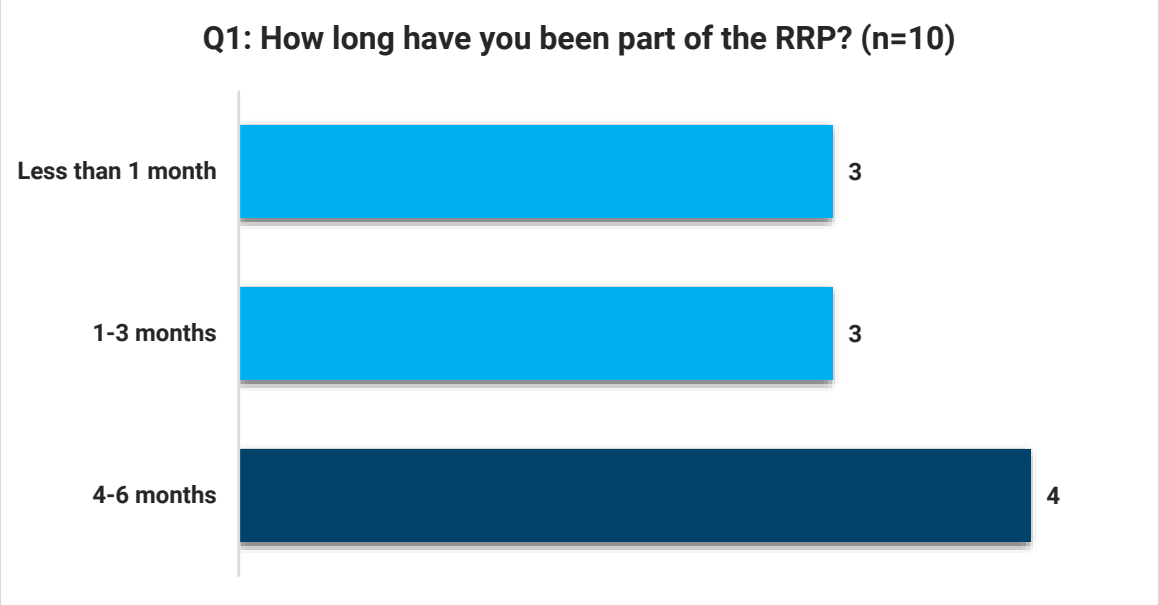
Appendix D: Client Satisfaction Survey

Client Satisfaction Survey

The *Client Satisfaction Survey* was administered to clients of the RRP. Using a combination of quantitative and qualitative questions, the *Client Satisfaction Survey* assessed several aspects of the client's experiences throughout the program such as opinions of the RRP staff, specific areas of the program that were helpful or unhelpful, insights to any changes in their aspects of daily life, and constructive criticism on how to improve the program. A total of 10 RRP clients completed the survey. The results of the survey are outlined by question below.

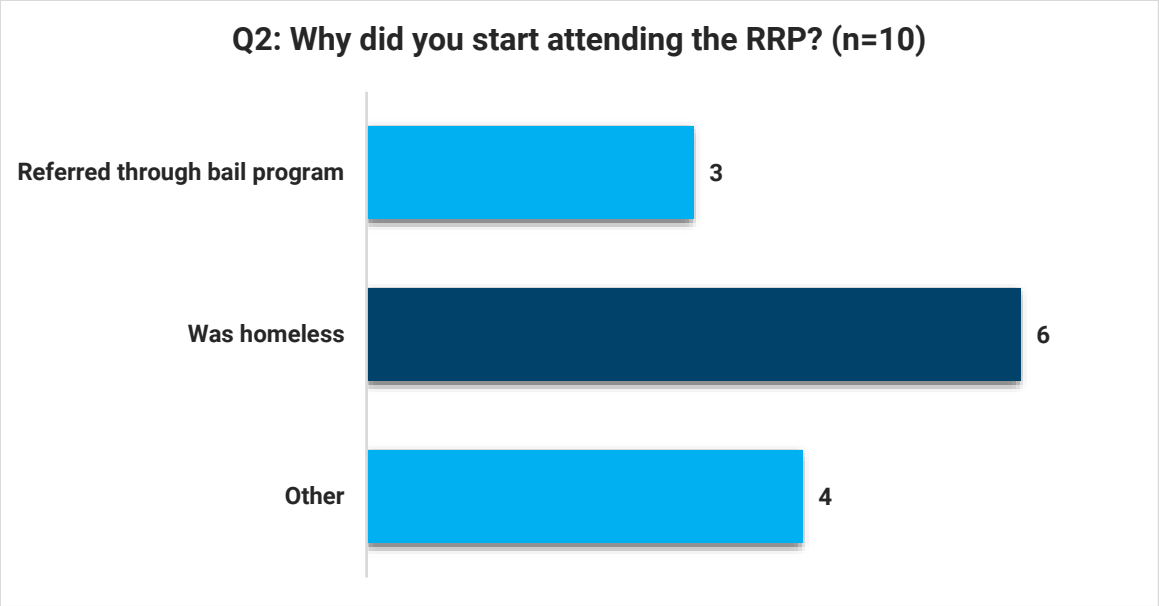
Q1: How long have you been part of the RRP?

First, clients were asked to indicate the amount of time they have been a part of the RRP. The answer options ranged from 'less than 1 month' to 'over a year.' Mixed responses were received, as four individuals stated they had been part of the program for '4-6 months,' while three individuals shared that they were involved in the program for 'less than 1 month' and '1-3 months.' No clients stated that they had been involved in the program for over 6 months.



Q2: Why did you start attending the RRP?

Next, clients were asked to share why they started attending the program. Most indicated that it was because they were homeless (n=6), while others indicated that they were referred through the bail program (n=3). There was also the option to select 'Other' if they listed options did not apply, four individuals selected 'Other,' which they specified: referred by detox (n=2), ONWA suggestions or were referred through another organization. No respondents selected 'referred by school' or 'referred by family/friends.'



Q3: Did you access food cupboards in the kitchen while in the residence?

Clients were asked to indicate whether they accessed food cupboards in the kitchen while they were in the residence. Most clients (n=8) stated that they did use the food cupboards, while only one stated that they did not.

Q4: Did you access clothing services while in the residence?

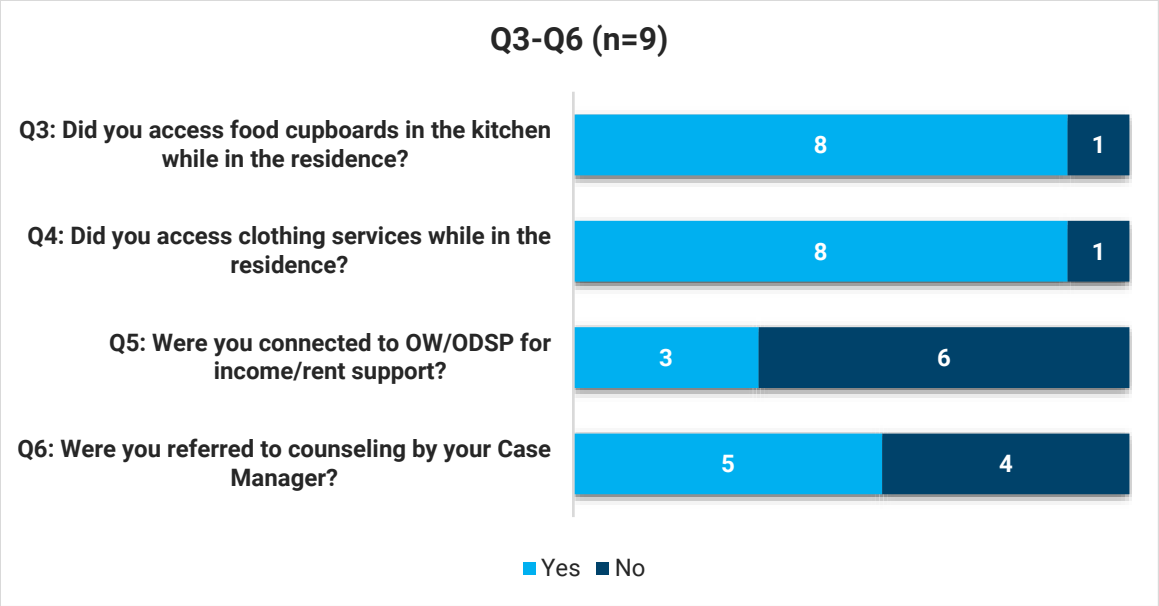
Clients were asked to indicate whether they accessed clothing services while they were in the residence. Most clients (n=8) stated that they did use clothing services, while only one stated that they did not.

Q5: Were you connected to OW/ODSP for income/rent support?

Clients were asked to indicate whether they connected to Ontario Works (OW) or Ontario Disability Support Program (ODSP) for income/rent support while they were in the residence. Most clients (n=6) stated that they did not connect with these services, while three stated that they did.

Q6: Were you referred to counseling by your Case Manager?

Clients were asked to indicate if their Case Worker referred them to counselling while they were in the residence. Most clients (n=5) stated that they did not connect with these services, while four stated that they did.



Q7: How would you rate the Intake Process that you experienced when you first entered the program?

Individuals were asked to rate their experience with the intake process when they first entered the program. Clients were provided with a 10-point Likert scale, with 1 indicating 'Very Negative' and 10 indicating 'Very positive.' The scale was condensed into a 5-point scale, combining a rating of 1 and 2 to 'Very negative,' a rating of 3 and 4 to 'Somewhat negative,' a rating of 5 and 6 to 'Neutral,' a rating of 7 and 8 to 'Somewhat positive,' a rating of 9 and 10 to Very positive.'

Overall, clients had a positive experience with the intake process when they entered the program, as three selected 'Very positive' and four selected 'Somewhat positive.' Only two respondents selected 'Neutral.'

Q8: How would you rate your experience during the process of moving into the residence?

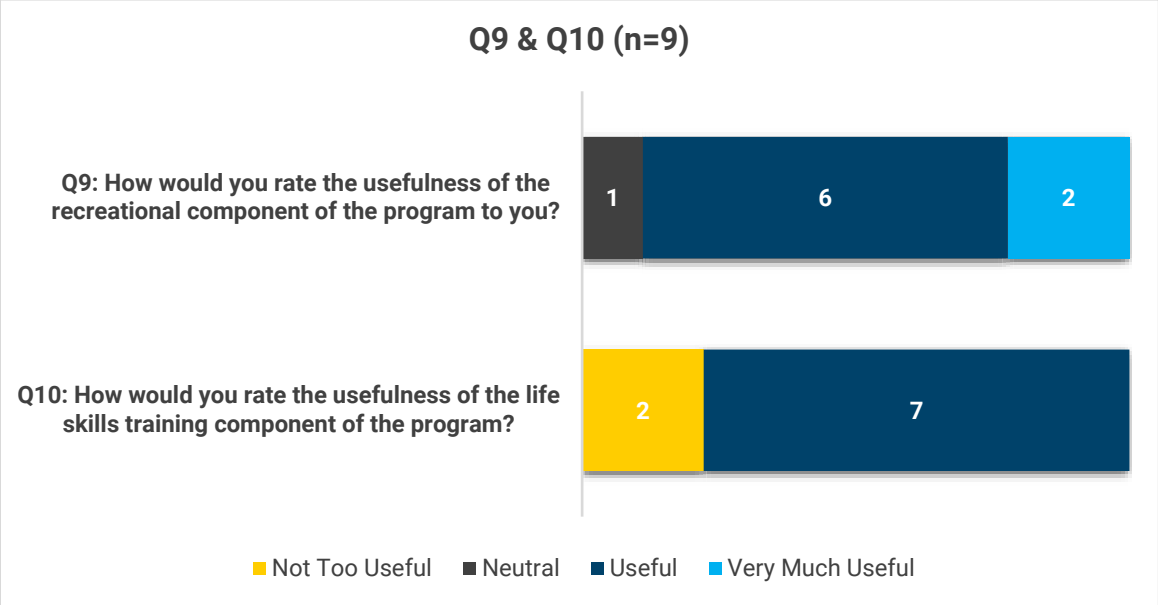
Using the same rating scale as the previous question, clients were asked to rate their experience during the process of moving into the residence. Individuals indicated that they had a positive experience moving into the residence as most selected 'Somewhat positive' (n=5), with fewer selecting 'Very positive' (n=2) and 'Neutral' (n=2).

Q9: How would you rate the usefulness of the recreational component of the program to you?
Individuals were asked to rate the usefulness of the recreational component of the program. Clients were provided with a 10-point Likert scale, with 1 indicating 'Not at all useful' and 10 indicating 'Very much useful.' The scale was condensed into a 5-point scale, combining a rating of

1 and 2 to 'Not at all useful,' a rating of 3 and 4 to 'Not too useful,' a rating of 5 and 6 to 'Neutral,' a rating of 7 and 8 to 'Useful,' a rating of 9 and 10 to Very much useful.'

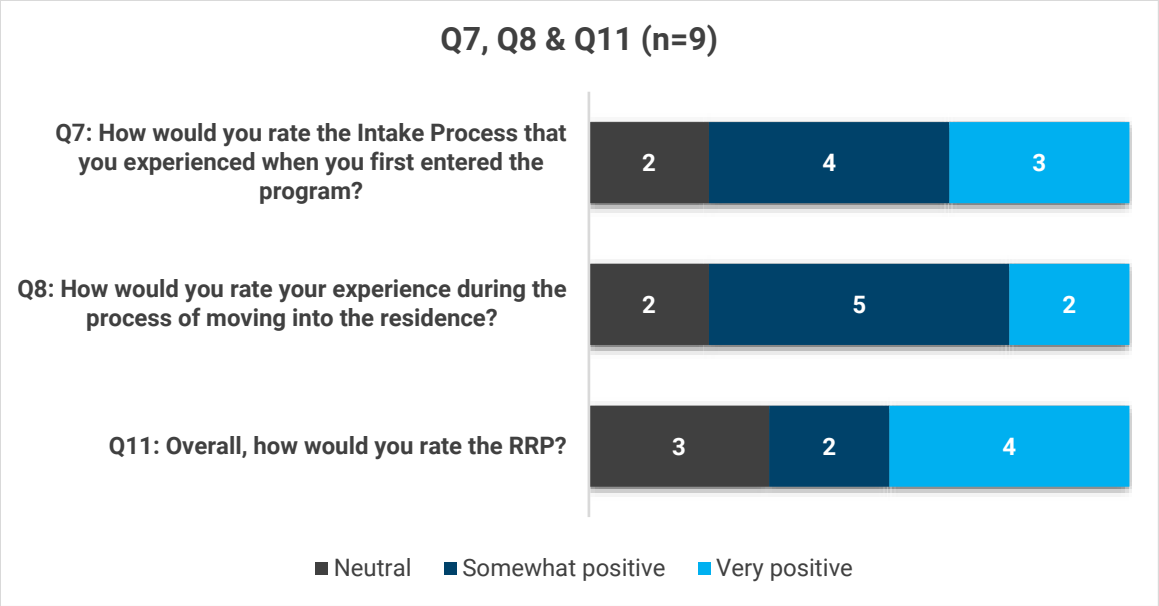
Overall, clients rated the usefulness of the recreational programing to be useful, as most rated it 'Useful' (n=6) and two rated it 'Very useful.' Only one individual selected 'Neutral.'

Q10: How would you rate the usefulness of the life skills training component of the program?
Using the same rating scale as the previous question, respondents were asked to provide their rating of the usefulness of the life skills training components of the program. Most respondents rated the life skills training component as 'Useful' (n=7); however, two individuals indicated that they found this component of the program 'Not too useful.'



Q11: Overall, how would you rate the RRP?

Next, using the same rating scale used in Q7 and Q8, clients were asked to rate their overall feelings towards the RRP. Overall, clients had a positive experience with the program, as four selected 'Very positive' and two selected 'Somewhat positive.' Three respondents selected 'Neutral.'

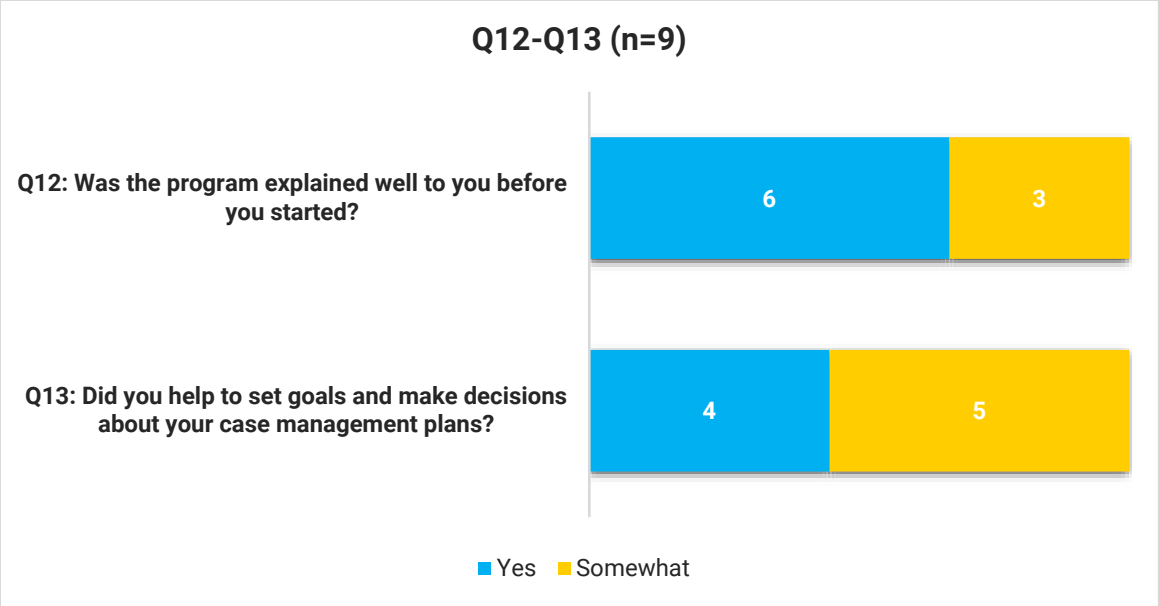


Q12: Was the program explained well to you before you started?

Clients were asked if the program was properly explained to them prior to joining/entering the program. Most clients selected 'Yes' (n=6), with fewer selecting 'Somewhat' (n=3).

Q13: Did you help to set goals and make decisions about your case management plans?

Clients were also asked if they were assisted in setting goals and making decisions related to their case management plans. Clients selected either 'Somewhat' (n=5) or 'Yes' (n=4).

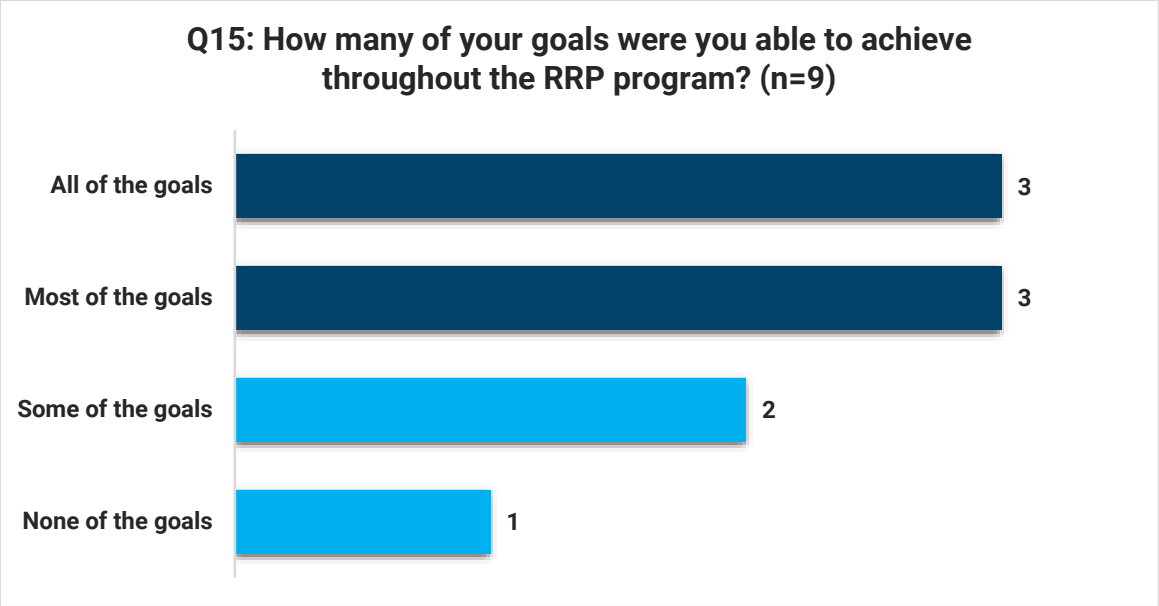


Q14: Please elaborate on your answer to the previous question.

Clients were asked to further elaborate on their response to Q13, which three individuals provided a response. One individual who selected 'Yes' shared that they were able to meet all of there goals. For those who selected 'Somewhat,' they shared that they were unsure what their goals were or that they achieved their goals on their own.

Q15: How many of your goals were you able to achieve throughout the RRP program?

Clients were asked how many of their goals which they set that they were able to achieve during their time with the RRP program. (*n*=3; 33%) indicated that they successfully achieved all of their goals; the same number said that they successfully achieved "most of their goals"; two participants (*n*=2; 22%) indicated that they successfully achieved some of their goals. Just one individual (*n*=1; 11%) said that they did not achieve any of their goals. See Figure 14 below.



Q16: Did you complete all the life skills programming set out into your Resident Action Plan (RAP)?

When asked if they had completed all the life skills programming within their Resident Action Plan (RAP) all respondents selected 'No' (*n*=8).

Q17: If no, why not?

When asked to elaborate, three individuals provided a response. Clients shared that they were not learning and thing and/or found it boring, they were too shy to attend, or they did not know any of the other residents who attended.

Q18: Do you like working with your Case Manager?

Clients were asked if they liked working with their Case Manager. Almost all respondents selected 'Yes' (n=8), while only one individual selected 'Somewhat' (n=1).

Q19: Please elaborate on your answer to the previous question.

Individuals were asked to expand on their response in Q18, which only one individual provided a response. This individual shared that their Case Manger was helpful in providing them with resources which addressed their needs.

"The Case Manager really showed the right approach by helping me get to the resources I needed to address some of the underlying issues I was facing."

Q20: Do you feel like your Case Manager respected you?

Clients were asked to indicate if they believe that their Case Manager respected them. Almost all respondents selected 'Yes' (n=8), while only one individual selected 'Somewhat' (n=1).

Q21: Please elaborate on your answer to the previous question.

Individuals were asked to expand on the response they selected in Q20, which two individuals provided a response. Responses demonstrated that clients perceive their Case Manager to be an active listener, compassionate, and caring.

"Great listener. [They] actually showed some compassion for my situation. Seemed to genuinely care about my well being."

"I felt like I could talk with her, and she was good at helping direct me with my needs."

Q22: Do you feel that your Case Manager was professional?

Clients were asked to indicate if they believe that their Case Manager was professional Almost all respondents selected 'Yes' (n=8), while only one individual selected 'Somewhat' (n=1).

Q23: Please elaborate on your answer to the previous question.

Individuals were asked to expand on the response they selected in Q22, which two respondents provided a response. Common responses demonstrated that clients perceive their Case Manager to professional as they are well-spoken, successful in following through, provide and thorough feedback.

Q24: Overall, how helpful has the Social Navigator been in helping you obtain and retain housing in the community?

Individuals were asked to rate the helpfulness of the Social Navigator in terms of helping in obtaining and retaining housing in the community. Clients were provided with a 10-point Likert scale, with 1 indicating 'Not at all helpful' and 10 indicating 'Very much helpful.' The scale was condensed into a 5-point scale, combining a rating of 1 and 2 to 'Not at all helpful,' a rating of 3

and 4 to 'Not too helpful,' a rating of 5 and 6 to 'Neutral,' a rating of 7 and 8 to 'Helpful,' a rating of 9 and 10 to Very much helpful.'

Overall, clients indicated that the Social Navigator was helpful in assisting with housing in community, as three individuals selected 'Very much helpful' and two selected 'Somewhat helpful.' Two individuals selected 'Neutral.' This question did not apply to two respondents, therefore they selected the 'Not applicable' option that was provided.

Q25: In what ways, specifically, would you say the Social Navigator has been helpful?

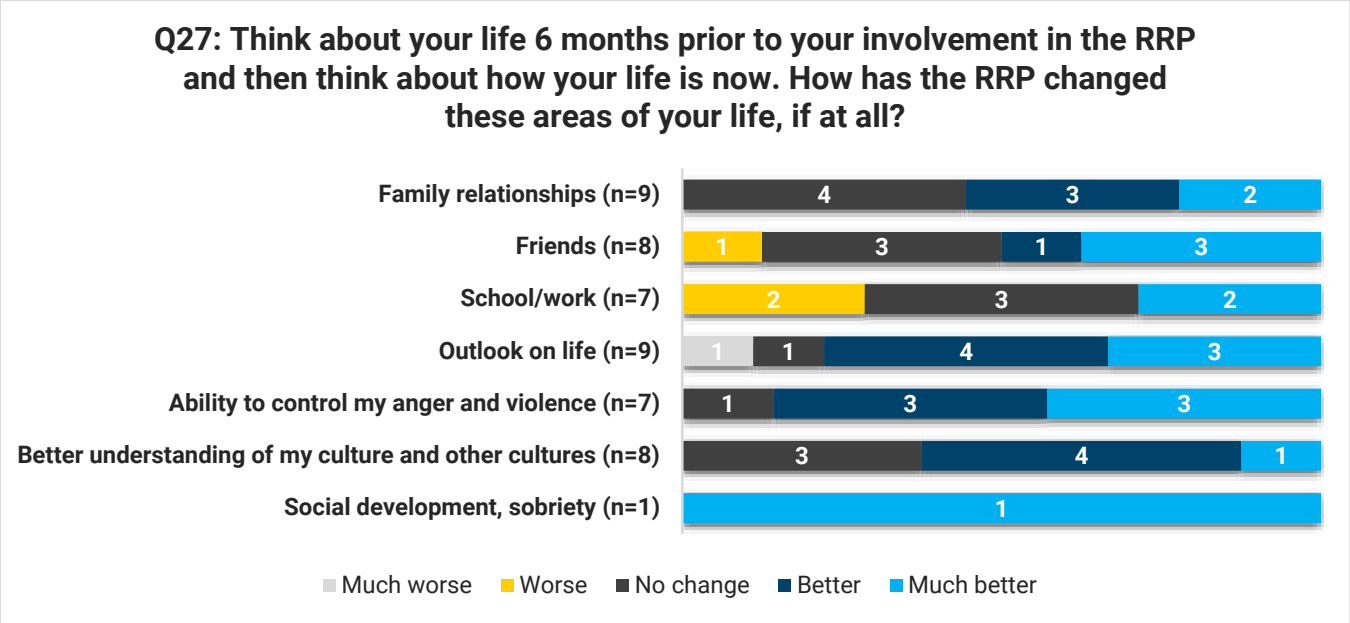
Individuals were asked to elaborate on the ways the Social Navigator has been helpful, which three individuals provided a response. Clients shared that the Social Navigator has been helpful with assisting in obtaining and completing applications and forms, meeting with them with social assistance workers, accommodating transportation to help them attend appointments, and helping them with everyday skills.

Q26: What ways, specifically, would you say the Social Navigator has <u>not been</u> helpful?

Next, individuals were asked to specify the reasons how the Social Navigator has not been helpful, where only two different reasons were provided. One, individual stated that the Social Navigator is always helpful, while the other shared that the Social Navigator's workload was too heavy, impacting their ability help to clients with their needs.

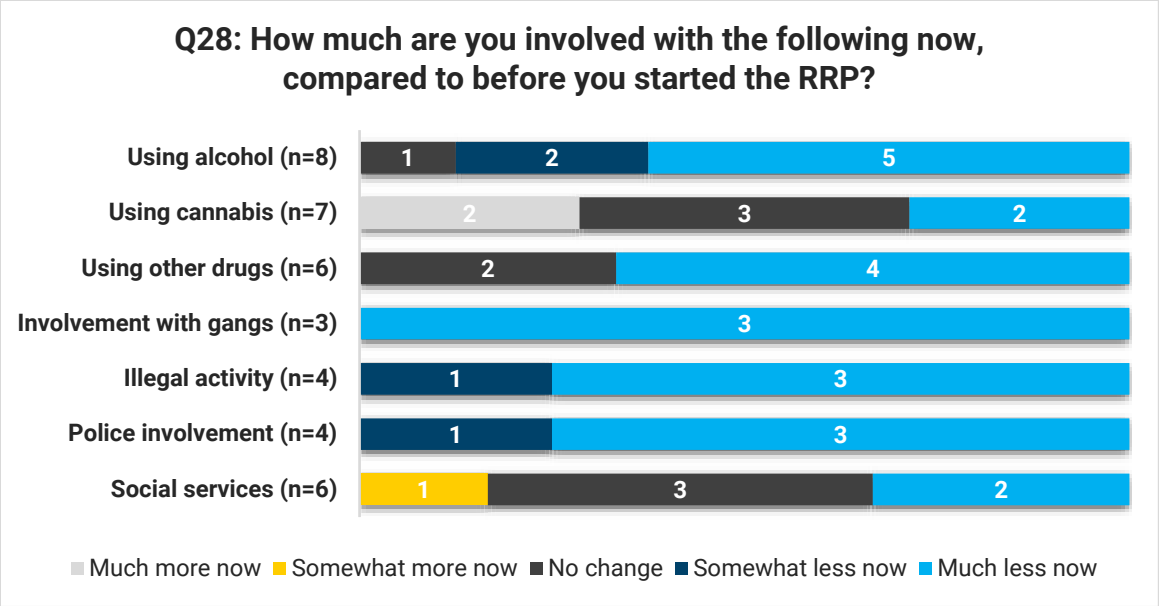
Q27: Think about your life 6 months prior to your involvement in the RRP and then think about how your life is now. How has the RRP changed these areas of your life, if at all?

Clients were asked to compare life 6 months prior to entering the RRP to how their life is right now, for a variety of components listed in the figure below. For the most part, respondents indicated that components have gotten 'Better' or 'Much Better' or 'No Change' has occurred. Fewer respondents shared some aspects have gotten 'Worse' or 'Much Worse,' however, two individuals shared that school/work has gotten 'Worse' since before the program and one individual shared that their involvement with 'Friends' has gotten 'Worse' since the program. One individual shared that their 'Outlook on life' has gotten 'Much Worse' since attending the program.



Q28: How much were you involved with the following now, compared to before you started the RRP?

Next, individuals were asked the rate their involvement with a variety of items listed in the figure below compared to before they started the RRP. The ratings ranged from 'Much more now' to 'Much less now.' Most clients indicated that they are involved in the listed items 'Much less now,' 'Somewhat less now,' or that there has been 'No change.' Fewer respondents shared engaging in certain behaviours 'Somewhat more now' or 'Much more now,' however, one individual share that they are involved with social services 'Somewhat more now' and two clients shared that they are using cannabis 'Much more now.'



Q29: What parts of the program do you believe helped the most?

Clients were asked to share the aspects of the program they believed helped them the most. Many stated that the RRP provided them with a place to stay and helped reduce homelessness. Other comments included: sobriety, life skills development, meeting new people, building friendships, and freedom. One individual discussed how the program has helped them become accountable due to having a stable place to come back to each night and the support they received from their Case Manager:

"Being held accountable for myself by having to come back there every night and working with a Case Manager to get involved with programming, therapy, treatment, etc."

Q30: What parts of the program do you believe were the least helpful or perhaps unhelpful?

Clients were asked to indicate aspects of the program which they believed to be least helpful. Only two individuals provided a response to this question. Respondents mentioned that they are fearful of the other individuals in the program and the program has not helped in providing them with schooling and employment opportunities.

Q31: Would you recommend this program to others?

Clients were asked if they would recommend this program to others, all respondents (n=8) selected 'Yes.'

Q32: Why or why not would you recommend this program to others?

When asked to indicate why they would recommend this program to other, six individuals provided a response. Individuals shared that the people in the program are helpful, positive, and respectful. Clients also shared that the program helps to make positive changes in their lives.

"If you're in a seriously bad place and want to make some serious life changes."

"It's a positive network of people that help individuals make positive changes."

Q33: Have you made positive changes in your life because of RRP?

Next, respondents were asked if the RRP has caused individuals to make positive changes in their life. Individuals either selected 'Yes' (n=5) or 'Somewhat' (n=4).

Q34: Please elaborate on how you've made positive changes in your life because of RRP.

When asked to further elaborate on the positive changes that had been made because of the RRP, five clients provided a response. Individuals discussed how they program has caused them to want to continue their education, work on their self-esteem and confidence, they are more independent, they were provided with stable accommodations/resources, and they are now able to move forward with their lives.

"It has given me the opportunity to re-establish myself as a functioning part of this community through proper counseling, medication, therapy, recreation programming, etc."

Q35: How can we make the program better?

Participants were asked to provide suggestions to improve the program, which eight individuals provided a response. Suggestions included adding more opportunities for cooking classes, Native arts and crafts, and Alcoholic Anonymous (AA) or Narcotics Anonymous (NA) meetings. Additionally, some participants would like to see more recreational programming, more introductions to other residents in the program, more food and drinks, and have more pamphlets available to share other resources available to clients.

Q36: Do you have any other comments/ideas you'd like to share?

Clients were provided the opportunity to include any additional comments or ideas about the program that they would like to share, where six individuals provided a response. Individuals shared that they found various aspects of the program helpful, which are described below:

"Provided stability and security in my life; I like how John Howard Society works with other organizations such as SOS, detox, and ONWA."

"This is a good place for help with individuals needs, directing them what they could do, what their options are. They help with explaining an individual's options, letting individuals know that there are resources out there. available any day of the week to help, no appointment needed."

"I really like the option to rebuild your own bike program and more need to better foods, even food voucher for fresh vegetables and fruit."

"Thank you for helping me find my way again."

Discussion

Overall, clients stated that their reasoning for accessing the RRP was because they were experiencing homelessness, or they were referred through bail. To address these needs, majority of clients utilized the food cupboard and clothing services provided at the RRP. Fewer individuals made use of the income/rent support program and counselling referrals made by the Case Manager.

Based on survey results, it is evident that clients at the RRP are extremely satisfied with the staff at the RRP. The surveys focused on client's perceptions of three different roles: the Case Manager, the Recreational Therapist, and the Social Navigator. Clients perceive the Case Manager to be extremely respectful, professional, and compassionate. Clients stated that the life skills programming and recreational therapy activities provided by the Recreational Therapist to be extremely useful. Lastly, clients provided that the Social Navigator is very helpful to them. Specifically, clients were asked if the Social Navigator has been helpful in retaining housing in the community, and majority indicated that they have been helpful. The only negative comment provided regarding the Social Navigator is that sometimes they are unavailable to help the clients due to their heavy workload.

Clients suggested that their experience throughout the RRP overall has been satisfactory and positive. This also includes their perceptions of and experiences with the intake process and moving into the RRP. Additionally, all individuals stated that they would recommend this program to someone else due to the help provided from the staff and the positive impact the program has made on their life. Further, clients indicated the most helpful and least helpful aspects of the

program. In terms of helpful aspects, many individuals suggested that the program has aided them is reducing homelessness, maintaining sobriety, developing life skills, building relationships and experiencing freedom. Additionally, clients have stated that the program has helped them in making various positive changes in their lives. Further, clients indicated that the program has helped them in managing their lives and progressing towards achieving their goals. In contrast, the unhelpful aspects of the program that were provided include lack of assistance with schooling and employment opportunities and being fearful of the other residents in the program. To improve the program, clients have suggested that they would like to be provided with opportunities to help work on improving self-esteem and confidence, continue schooling, become more independent, and move on with their life. Clients also suggested that they would like to see more programming implemented throughout the RRP. Examples of programming include cooking classes, Indigenous artis and crafts, Alcoholics Anonymous (AA), Narcotics Anonymous (NA), recreational activities, and relationships building activities. Additionally, individuals desire more supports specifically for housing, schooling, and employment opportunities.

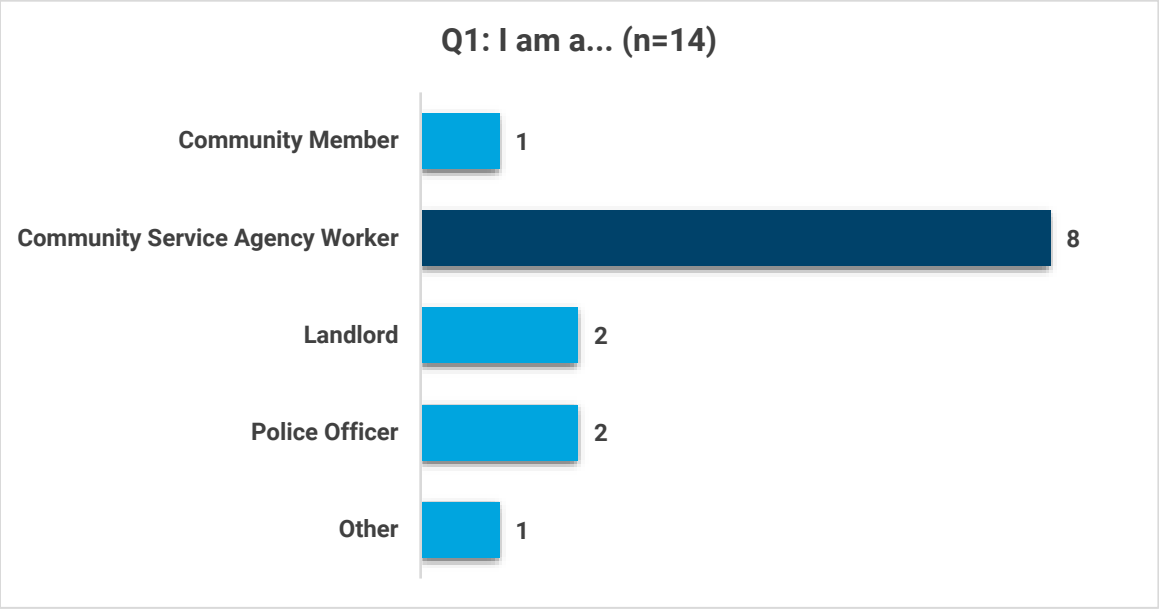
Appendix E: Community Partner Satisfaction Survey

Program Stakeholder Satisfaction Survey

The *Program Stakeholder Satisfaction Survey* was administered to external partners of the RRP including, community service agency partners, landlords, police officers and community members. Using a combination of quantitative and qualitative questions, the *Stakeholder Satisfaction Survey* measures community partner' overall satisfaction with the RRP based on a variety of program components such as: level of engagement with the program and staff, level of support from the organization, program efficiency. Stakeholders were also asked to provide feedback on program successes and limitations to determine what works and what could be improved. A total of 14 stakeholders completed the survey. The results of the survey are outlined by question below.

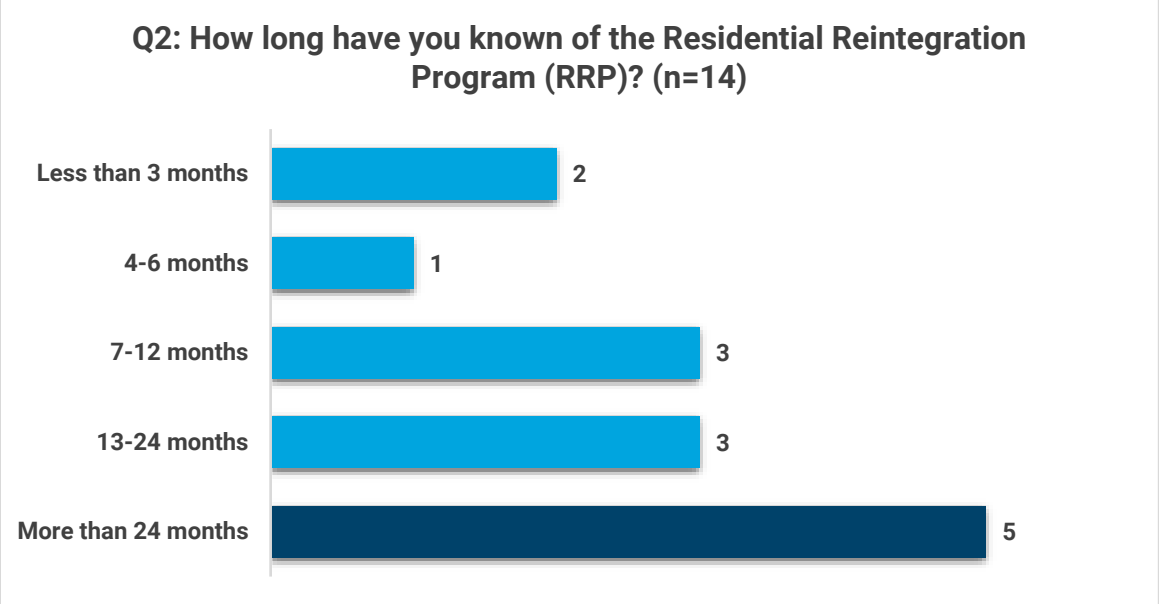
Q1: I am a…

Respondents were asked to provide their occupation from a list of categories. The majority (n=8) identified as a 'Community Service Agency Officer,' while fewer identified as a 'Police Officer' (n=2), 'Landlord' (n=2), or 'Community Member' (n=1). Only one individual selected 'Other', which they specified that they are a 'Funder.'



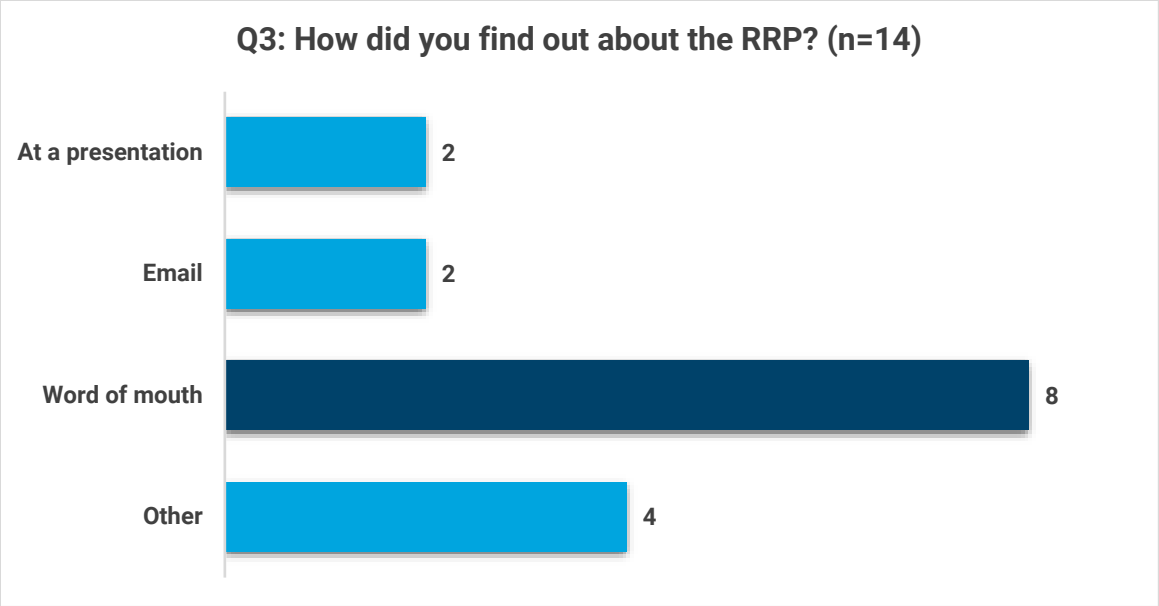
Q2: How long have you known of the Residential Reintegration Program? (RRP)

Stakeholders were asked to share how long they have known about the RRP. Mixed responses were received; however, most stated that they have known about the RRP for 'More than 24 months' (n=5), with fewer knowing about the program for '13-24 months' or '7-12 months' (n=3).



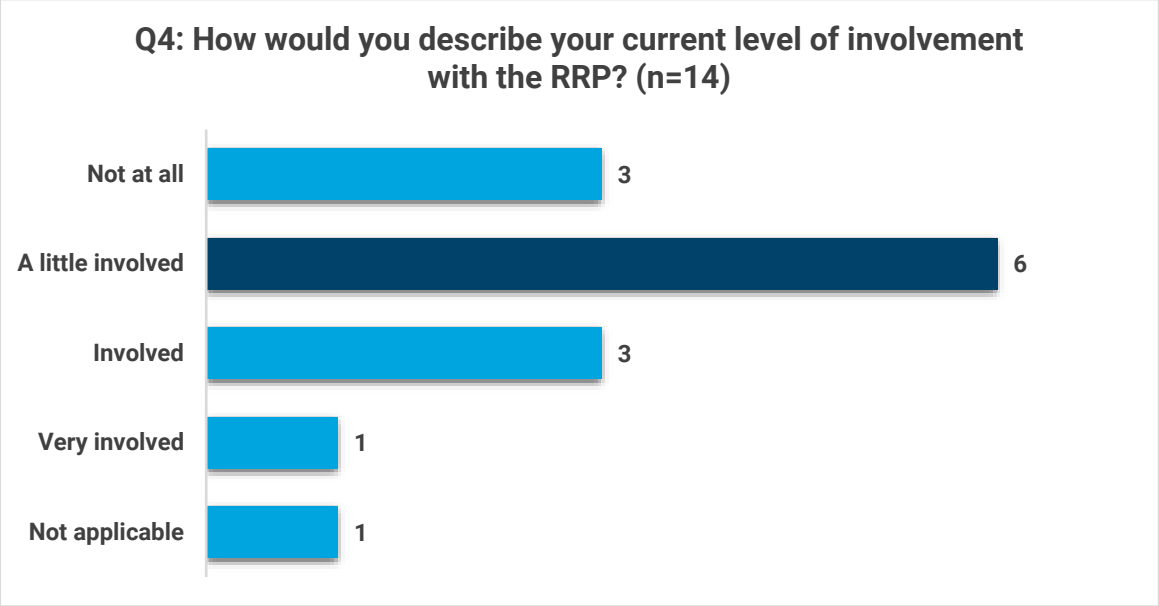
Q3: How did you find about the RRP?

Respondents were asked to indicate how they found about the RRP program. For this question, the list of options were not mutually exclusive, meaning that they could select more than one option. Most individuals selected 'Word of mouth' (n=8) or 'Other' (n=4), with few selecting 'At a presentation' or 'Email' (n=2). No respondents selected 'Internet', 'Newspaper', or 'TV or radio.' Of those who selected 'Other,' they further specified that they found out about the program through worked directly with previous Executive Director, agency programming on-site, information provided by JHS, or through staff at their agency/organization.



Q4: How would you describe your level of involvement in RRP?

When asked for respondents to describe their level of involvement in the RRP program, majority indicated being 'A little involved' (n=6), with fewer selecting 'Involved' or 'Not at all' (n=3).

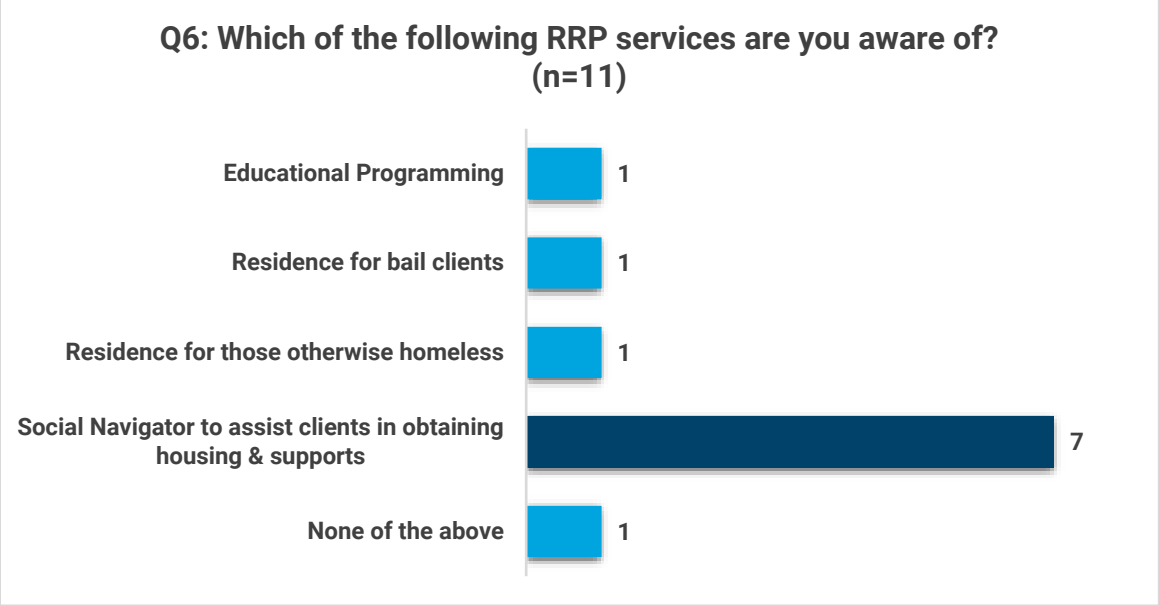


Q5: In what ways, if any, has COVID-19 impacted your involvement with the RRP?

Stakeholders were asked to share they ways that COVID-19 has impacted their involvement with the RRP, which five individuals provided a response. Three respondents shared that COVID-19 has limited and reduced their ability to provide programming and services to RRP clients. One shared that it has impacted their ability to make referrals to the program due to decreased face-to-face interactions and another stated that extra protocols have been put into place.

Q6: Which of the following RRP services are you aware of?

Stakeholders were asked to indicate which of the listed RRP services they were aware of. Most selected 'Social Navigator to assist clients in obtaining housing & supports' (n=8), while only one individual selected 'Educational Programming,' 'Residence for bail client,' 'Residence for those otherwise homeless,' or 'None of the above.' No stakeholders selected 'Client-centered Case Management' or 'Recreational Activities.'



Q7: How would you rate your satisfaction with following aspects of the RRP?

Using a 4-point Likert scale ranging from 'Very Dissatisfied' to 'Very Satisfied,' respondents were asked to rate their satisfaction on the following three statements. 'Not applicable' was also provided as an option.

Overall satisfaction with the RRP

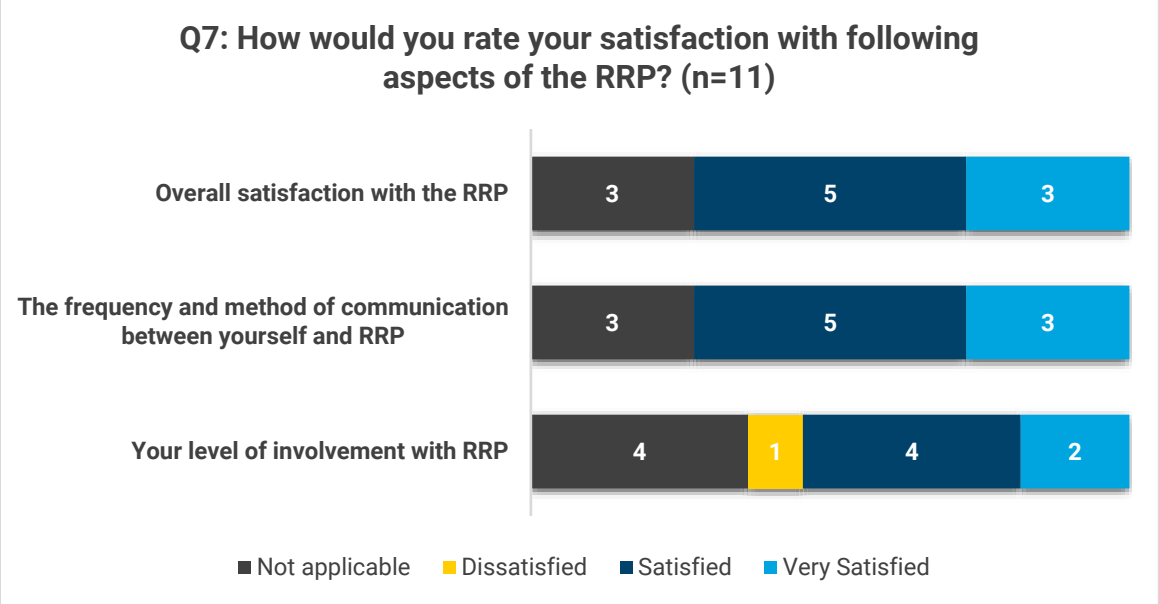
Respondents were asked to rate their overall satisfaction with the program, where they either stated that they were 'Satisfied' (n=5) or 'Very Satisfied' (n=3) with the program. Three respondents selected 'Not applicable.'

The frequency and method of communication between yourself and RRP

Next, respondents were asked to rate their satisfaction regarding their communication between themselves and the RRP, where most indicated 'Satisfied' (n=5) or 'Very Satisfied' (n=3). Three respondents selected 'Not applicable.'

Your level of involvement with the RRP

Last, respondents were asked to rate their satisfaction in terms of involvement with the RRP, where most selected 'Satisfied' (n=4) or 'Very Satisfied' (n=2); however, one respondent selected 'Dissatisfied' and four respondents selected 'Not applicable.'



Q8: Please elaborate on your level of satisfaction with the RRP.

Stakeholders were asked to further elaborate on their level of satisfaction with the program, which eight individuals provided a response to. Respondents shared that RRP has been a positive point of contact for new tenants entering social housing, the program is successful in assisting their target population on an individualized client basis, the staff focus on client engagement and community access to health and wellness, and that they have a very good working relationship. Others shared that they would like to be more involved with the mutual clients that they refer to the program and that due to COVID-19 their communication with the program has reduced significantly.

Q9: From your perspective, what are the best features of the RRP?

Respondents were then asked to highlight the features of the RRP that they believed to be the best, nine individuals provided a response. Some respondents highlighted that being client-centered and focussing on individual needs was a defining feature. Others highlighted the Social Navigator and associated responsibilities as the best feature:

"Social Navigators are the highlight of the RRP. They are caring and assist people with housing and basic needs whether or not they are living at John Howard or not".

"Assistance navigating housing issues."

"Offers support and services to meet the needs of those trying to reintegrate into the community".

Q10: From your perspective, what are the weakest or most challenging features of the RRP?

Next, respondents were asked to identify any weak points or challenges encountered by the RRP, seven individuals provided a response. No constructive feedback was received; however, respondents did identify challenges that the RRP faces with the clientele they serve and the limited resources that they have:

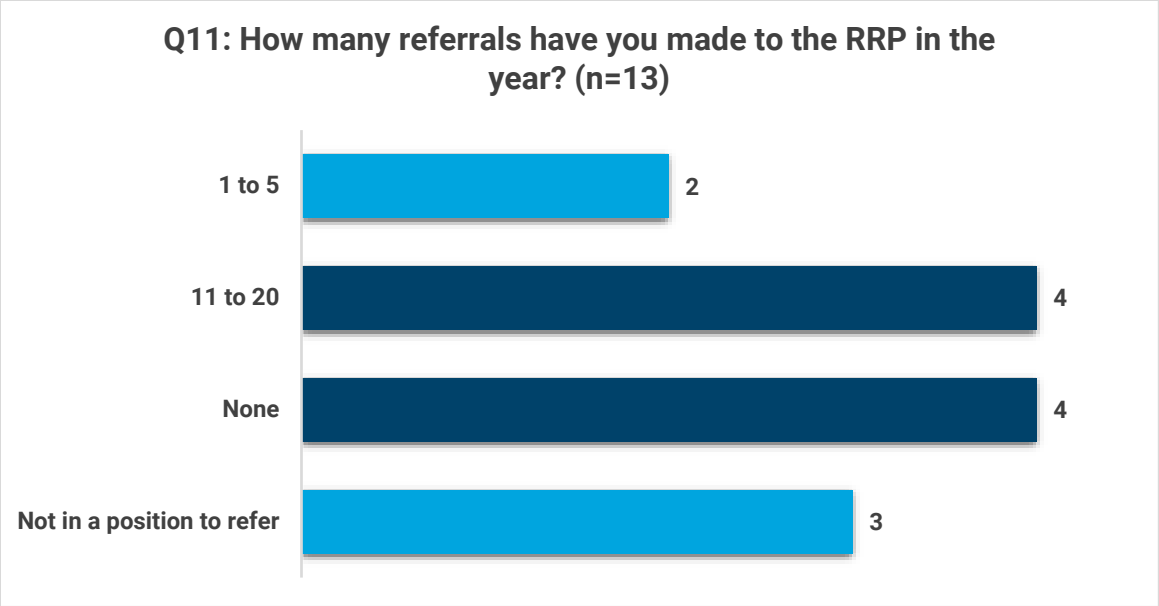
"The degree of complex Mental health requires a team of folks working with people."

"The difficulty at times to secure attainable funding to support programs and services that are vital to the residents they serve."

"They don't have enough resources to do more of their great work!"

Q11: How many referrals were made in a year?

Respondents were asked how many referrals were made in last year. Out of those who did make referrals in the past year, four stated that they made '11 to 20,' while two selected '1 to 5.' Four stated that did not make any referrals and three stated that they are 'Not in a position to refer.'

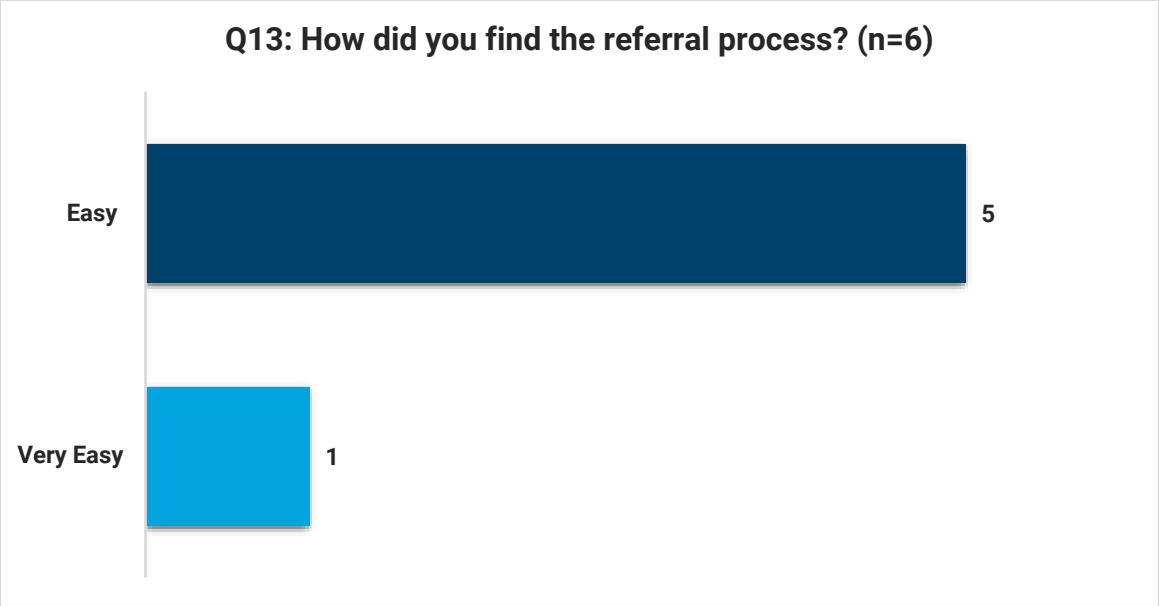


Q12: If they were in a position to refer, but made no referrals, please explain why.

Those who stated that they did not make any referrals in the past year in the previous question, were asked to provide a reason why they did not. Only two respondents provide a response, where they stated that they had a lack of awareness or that due to their position, they do not provide direct services to clients.

Q13: How did you find the referral process?

Next, respondents were asked to rate how they found the referral process on a 4-point scale ranging from 'Very Difficult' to 'Very Easy.' Out of the six respondents (n=6), most selected 'Easy' (n=5), while one selected 'Very Easy.'



Q14: Please elaborate on why you found the referral process difficult.

Although no respondents indicated that they found the referral process difficult in the previous question, one individual provided a response when asked to expand on why they found the referral process difficult:

"It's a much need component of the continuum of housing supports in this community."

Q15: Based on your experience, please rate the extent to which you agree with the following statements:

Using a 4-point Likert scale ranging from 'Not at all' to 'Very much,' respondents were asked to rate their agreement with the following three statements. 'Not applicable' was also provided as an option.

I was aware that I could refer clients to participate in RRP programming even if they were non-residents.

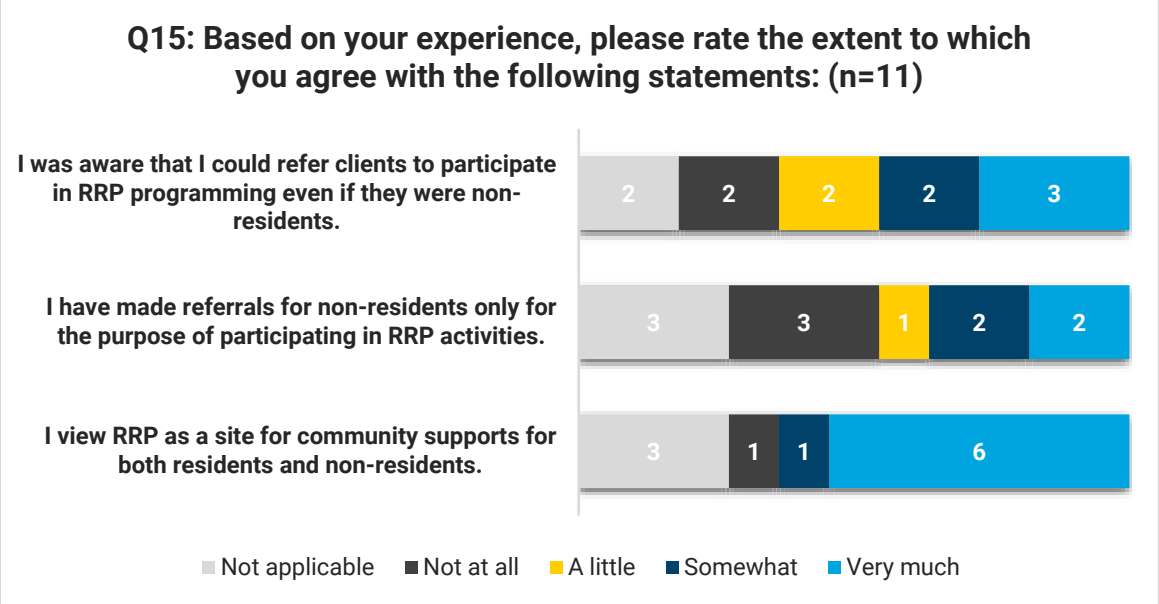
Respondents were asked to rate their agreement with whether they were aware that they could refer clients to the RRP program even if they did not live in the residence. Out of the eleven respondents, mixed responses were received. Three shared that they were 'Very much' aware, while two individuals selected "Not at all,' 'Somewhat,' 'A Little,' or 'Not Applicable.'

I have made referrals for non-residents only for the purpose of participating in RRP activities.

Next, respondents were asked if they made referrals for non-residents to participate in RRP activities. Out of 11 respondents, mixed responses were received. Three selected 'Not at all' or 'Not applicable,' while two selected 'Somewhat' or "Very much' and only one individual selected 'A little.'

I view RRP as a site for community supports for both residents and non-residents.

Last, respondents were asked to rate their agreement with whether they view RRP as a site for community supports for both residents and non-residents. Most selected 'Very much' (n=6) or 'Not applicable' (n=3), while only one individual selected 'Not at all' or a "A little.'



Q16: To what extent do you agree with the following statements about the RRP:

Using a 4-point Likert scale ranging from 'Strongly Disagree' to 'Strongly Agree,' respondents were asked to rate their agreement with the following four statements. 'Not applicable' was also provided as an option.

My experience with the RRP has been a positive one.

Respondents were asked to rate their agreement with whether their experience with the RRP has been positive. Most selected either 'Agree' (n=5) or 'Strongly Agree; (n=3). Only two participants selected 'Not Applicable.'

I would be comfortable bringing an issue to the attention of RRP staff.

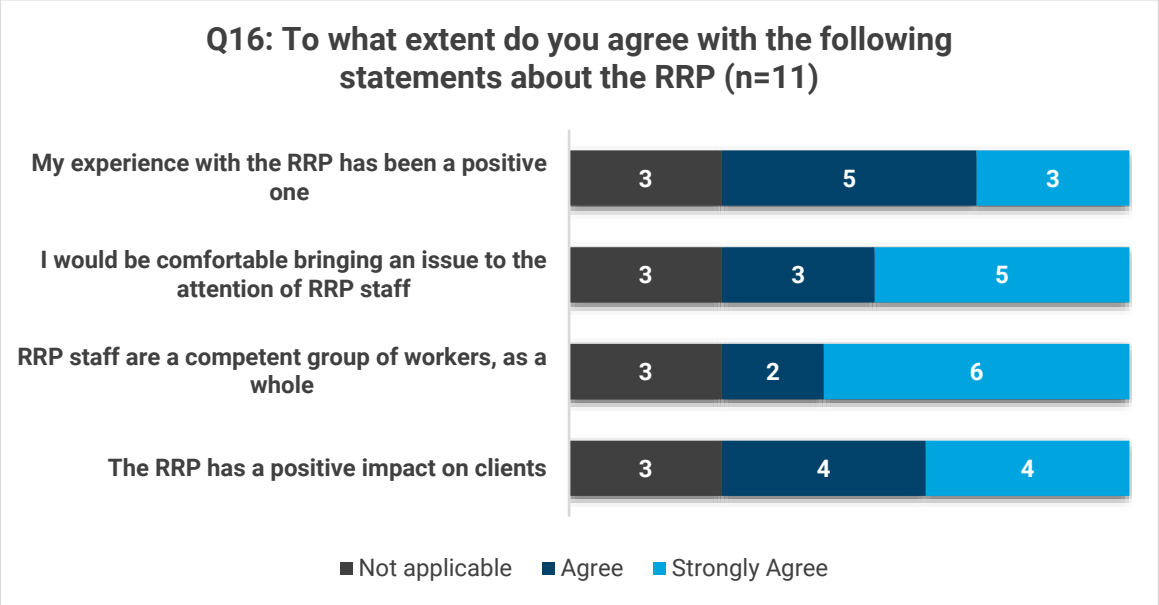
Respondents were then asked to rate their level of agreement with whether they would be comfortable bringing an issue to the attention of the RRP staff. Most respondents selected either 'Strongly Agree' (n=5) or 'Agree' (n=3). Three individuals selected 'Not applicable.'

RRP staff are a competent group of workers, as a whole.

Next, respondents were asked to rate their level of agreement with the statement asking if they believed that RRP staff were competent workers. Most respondents selected either 'Strongly Agree' (n=6) or 'Agree' (n=2). Three individuals selected 'Not applicable.'

The RRP has a positive impact on clients.

Last, respondents were asked to rate the level of agreement with whether they believe the RRP has a positive impact on its clients. RRP had a positive impact on clients. Most respondents selected either 'Strongly Agree' (n=4) or 'Agree' (n=4). Three individuals selected 'Not applicable.'



Q17: Please elaborate on your overall experience with the RRP.

Respondents were then provided the opportunity to further elaborate on their experience with the RRP, which five individuals provided a response. Of those who provided feedback, stakeholders shared that the program has provides support to a difficult to reach clientele and believes the program should be expanded to meet the high demand:

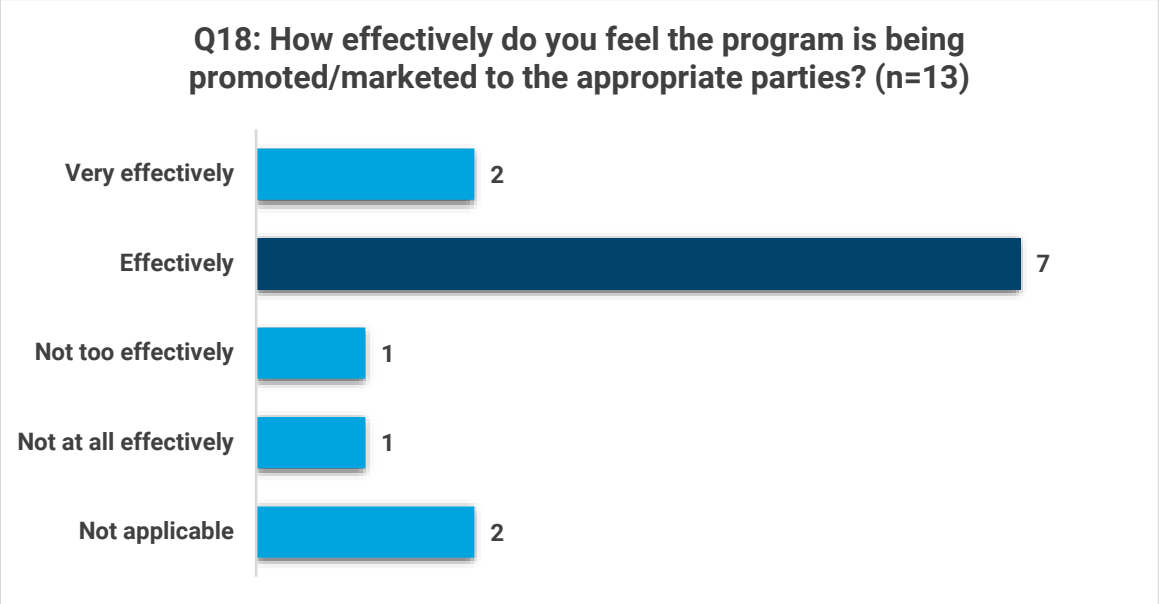
"From the input I have received, follow up is difficult with the transient nature of folks we refer and the few who are able to be reached have not followed thru with support services offered."

"The staff were incredibly supportive and responsive to making certain the men and women were active participants in their healing journey."

"Very good program, just needs to be expanded to meet demand."

Q18: How effectively do you feel the program is being promoted/marketed to the appropriate parties?

Respondents were asked to rate on a 4-point scale ranging from 'Not at all effectively' to 'Very effectively,' whether they believed the program was being promoted/marketed appropriately. Most respondents selected that they believed the program was being marketed and promoted 'Effectively' (n=7).



Q19: Would you recommend this program to potential referring agencies/workers?

Individuals were asked if they would recommend this program to potential referring agencies/workers. All respondents selected 'Yes' (n=14).

Q20: Please explain why you would or would not recommend this program

Respondents were asked to elaborate on why they would recommend this program to others, which eight individuals provided a response. Many mentioned that the program is essential for

securing and maintaining housing and assisting in navigating housing options, they program makes a positive difference, and the organization supports focusses on the needs of vulnerable clients with high needs.

"[The] program is making a positive difference for clients."

"I support agencies that are focused on the needs of the most vulnerable client. The John Howard Society of Thunder Bay does just that."

Q21: In what ways, if any, could the program be improved?

Next, respondents were asked to provide any feedback on how the program could be improved, seven individuals provided a response. Of those that provided feedback, most shared that they program requires additional resources and funding to continue provided the supports and services. Others suggested increased communication with community partners and providing more follow-ups with clients who have completed the program.

"They need more funding to support their workforce. Staffing is our biggest cost, and we need continued dollars to support retention."

Q22: Please provide any additional comments on any aspect of this program here.

Lastly, respondents were provided the opportunity to include additional comments about the program. Only one respondent provided a comment:

"As a community partner, I am pleased to call the John Howard Society a true grassroots program."

Discussion

Program stakeholders involved in the survey included mainly community service agency workers, landlords, police officers, and community members. Although most found the referral process to be a success, many stakeholders shared that COVID-19 limited their ability to provide programming and services to RRP clients and their ability to make referrals to the program due to decreased face-to-face interactions. Most stakeholders shared that the services they were most aware of was the housing supports provided by the Social Navigator and some even highlighted the housing supports to be the most positive feature of the program. In terms of program challenges, stakeholders mentioned that the program would benefit from additional funding and resources to better address the complex needs of their clients.

The survey results demonstrated that program stakeholders were satisfied with various aspects of the program including their communication with the program, their involvement with the program, the positive impact the program has on clients, and program staff. All stakeholders shared that they would recommend this program to others and many believe that the program makes a positive difference in the lives of vulnerable clients with unique needs.

7.3. Tools Designed by the Evaluation Team

Appendix F: Description of the Evaluation Instruments

Attendance & Program Tracking Form: Client Managers record attendance using open-ended forms. To facilitate extraction of participation information, this tracking form was used by the Case Manager to track individual participants' weekly programming, attendance, and progress, as well as to provide summary information for each participant. Client attendance and program information was entered into an Information Management System (IMS) by a Data Entry Assistant.

Client Satisfaction Survey: Assessed several aspects of the resident's experience with the program, such as impressions of program staff, aspects of the program that were helpful or unhelpful, perception of changes in several aspects of daily life, and suggestions of how to improve the program. The instrument used a combination of quantitative and qualitative questions and was administered upon program exit.

Client Status Survey: Assesses how well the client is fairing at monthly scheduled meetings. It is brief, designed to be administered by the Case Manager and aims to be a timely measure of how well things are going for residents and to ensure that any unmet needs are addressed. The instrument includes a combination of quantitative and qualitative questions to continually monitor resident experience while in the program. This information will be entered into the IMS on a regular basis by a Data Entry Assistant. The frequency of collecting data for the Client Status Survey was reduced from monthly to every three months.

Community Partner Satisfaction Survey: Measures community partners' satisfaction with the RRP using a combination of quantitative and qualitative questions. This survey is given to external partners on an annual basis using Survey Gizmo. Partners include landlords and community service agency partners. Respondents are asked to rate their level of engagement with the program and staff as well as the level of support from the organization. They are also asked to rate the structure of the RRP program in terms of efficiency, competency, approachability, and so on. Using open-ended questions, partners are asked to comment on the most and least preferred aspects of working with the program and to provide their suggestions for improvement.

Evaluation Consent Form: Prior to receiving any data collected from clients, each resident—except for CSC clients who were ineligible--went through an informed consent process to ensure they are fully informed of their rights, the purpose of the study and the use and treatment of their data. Participation in the evaluation was voluntary and meets the ethical standards of TCPS-2. A total of 56 consent forms were signed from November 2018 to October 2019.

Evaluation Tools Signoff Form: This form was intended to be placed at the front of every client's file. Upon completion of the administration of each of the scheduled data collection tools (i.e., evaluation consent form, pre-post assessment, intake form, SPIn risk assessment, Resident Action Plan, Client Satisfaction Survey), the person responsible for its administration signs the appropriate place on the form to indicate its completion and availability for transfer of the data to the IMS.

Information Management System: All quantitative and qualitative information from the tools were entered into an MS Excel Information Management System (IMS) or in an online survey management system (Alchemer). All of the data required for the evaluation from intake and attendance forms were entered into the IMS by the Data Entry Assistant at JHS-Thunder Bay. The data collected through each tool was entered into individual MS Excel sheets and stripped of any identifying information. The IMS also includes a dual password protection, with both the file and individual sheets/sections having passwords.

Intake Form: The intake form was completed by all participants in the program. It collected basic demographic information such as age, gender, ethnicity and referral information. It also recorded additional information about the client including: education, family, income, mental health and past encounters with the criminal justice system. The intake serves as the primary data collection tool to determine whether the program targeted the intended target population. This form was revised by the evaluation team to include more lists and categorical responses, in order to facilitate quantitative analyses. Only data required for evaluation purposes was be extracted from the intake forms and entered into the IMS.

Recreational Therapist Activities Form: A form that provided a means of easily tracking the participation in recreational therapy programs on an individual basis. The Recreational Therapist provides activities for RRP residents, JHS-Thunder Bay clients and the community. Similar to the Social Navigator Tracking Form, this form was creating an undue burden for the Recreational Therapist.

Resident Action Plan (RAP): Set out the client's goals and planned activities while participating in the program. It is typically completed in collaboration between the Client and Case Manager, using a client-centered approach, within the first two weeks of the program. It is reviewed and revised as client interests and circumstances shift. For each RAP, clients identified three goals that they would like to achieve and also the resources that they will require.

Resident Tracking Sheet: Used by the Case Manager to keep track a running tally of the number of clients residing in the building and those on the waiting list. It was updated on a weekly basis; however, that was reduced to a monthly basis to reduce burden on staff.

Social Navigator Tracking Form: A form that provided a means of tracking the key activities of the Social Navigator. It was updated on a weekly basis. The form required a significant amount of information regarding client referrals and since referrals for residents were made by caseworkers and other members of the RRP team, collecting this information was cumbersome for the Social Navigator. The form also excluded important information regarding housing outcomes for residents after leaving the RRP program. The Evaluation Team then updated the Social Navigator Tracking Form to better reflect the role and activities of the Social Navigator. The revised version captures participants who have left or who are planning to leave the program.

Appendix G: Case Note Checklist

Case Note Checklist

Case Notes Revealing Info on the following Process & Monitoring Indicator(s):

- Attendance in program activities
- Engagement with psychosocial programming / mental health services
- Engagement with Social Navigator
- Impact of COVID-19 on the program / individual
- Nature of contact / relationships with landlords
- Other program / service themes (list here):

Case Notes Revealing Info on the following Outcome Indicator(s):

- Employment / educational attainment
- Life skills / ability to live independent (e.g., cleaning, budgeting, etc.,)
- Self-efficacy & mental well-being (e.g., emotional regulation, coping skills, etc.,)
- Supplemental outcomes / other outcomes themes (list here):

Appendix H: Evaluation Consent Form

NAME: _____ AGE: _____

CLIENT ID: _____ DATE (DD/MM/YYY): _____

Evaluating the Residential Reintegration Program (RRP) at JHS Thunder Bay

You are being invited to participate in an evaluation of the RRP, which is being conducted by the Centre of Research, Policy & Program Development at the John Howard Society of Ontario. **Your participation in this evaluation is completely voluntary for all clients, including bail clients and those with court-mandated conditions. There will be no impact on your access to RRP services or the frequency and quality of services provided through RRP or other programs or services at any other agency, if you choose not to participate**.

The purpose of the evaluation is to see if the RRP is meeting its goals. Being a part of the evaluation will let us know if and how the RRP helped you, which will help us to make it the best program possible. Information from your intake meeting with John Howard of Thunder Bay staff, assessments, the services you received, and program attendance will be included in the evaluation, and you will have the opportunity to share your thoughts about the experience through an online or paper survey. Assistance can be provided with reading and responding to these written surveys, if needed.

In addition, staff will meet with you 6 months and 1 year following transition out of the program and into the community to find out how well you are doing. Data from these follow-up meetings will also be used in evaluating the success of the program.

You will receive a gift card for participating in the evaluation in the amount of $25 at the 6month follow-up meeting and $35 at the 12-month follow up meeting.

Protecting your privacy

This evaluation is being conducted by a professional Evaluation Team who are all employees or volunteers, at the John Howard Society of Ontario, who are bound by a confidentiality agreement. The team will ensure that all data collected and stored in the process of executing the RRP as well as data collected by online or paper surveys will be done so in a way that is secure and completely confidential. Here's how we will protect your privacy:

1. Your name will not be put on any data that we collect. Instead, all of your data will be linked only by a code number.

2. A file that connects the code numbers with your name and contact information will be stored in a locked cabinet separately from the information collected. As soon the evaluation is finished, and a final report issued, this file will be destroyed.

3. Your name will never appear on any of the research reports that result from this project.

4. All people involved in the collection of information have signed an agreement that they will not share the information with anyone else but the Evaluation Team.

5. None of the data collected for this evaluation will be given to any outside parties such as the police, the courts, or shared with an employer or case worker from OW/ODSP.

6. All data collected in paper form will be stored in locked cabinets; all data collected electronically will be stored in password protected servers. For both paper and electronic data, only JHS Thunder Bay staff and the Evaluation Team will have access.

What If You Change Your Mind About the Evaluation?

As indicated above, your participation in the evaluation is entirely voluntary. You may withdraw at any time without any consequences and request for any information collected not to be used. Ending your participation in the evaluation will have no impact on your access to RRP services or frequency and quality of services provided through RRP or other programs or services at any other agency.

Have Questions?

If you have any questions about the Residential Reintegration Program, now or at a later time, you can speak to an RRP Case Manager at 807-935-1304. If you have any questions about the Evaluation of the RRP, now or at a later time, you can contact the Lead Evaluator, Terry Borsook, at the John Howard Society of Ontario by phone at (416) 408-4282 x 231, or email at tborsook@JohnHoward.on.ca.

If you wish to participate, please check all that you agree to:

☐ I have read this consent form (or have had it read to me) and understand it.

☐ I want to participate in the evaluation of the RRP and I know who to contact if I have questions about the evaluation.

☐ I understand that my participation is voluntary, and I may withdraw, at any time, without consequences to accessing programs or services at John Howard Society Thunder Bay or any other agency.

☐ I understand that all information will remain confidential. I will never be identified by name nor will any identifiable information be released in the evaluation.

☐ I allow the professional Evaluation Team at the John Howard Society of Ontario access to the following information as it relates to my involvement in this program: referral and intake information, service plans, and any case management files.

Signature: _____ Date: _____

Phone number (if available): _____

Email (if available): _____

Appendix I: Pre-Post Assessment

Appendix J: Client Satisfaction Survey

The program Evaluation Team would like to know what you think of the Residential Reintegration Program (RRP) at the John Howard Society Thunder Bay. This survey is completely anonymous. Your name is not on this survey and no one from the RRP will see your answers. Your honest feedback is very important to us and will be used to help improve the program.

1. How long have you been part of RRP?

( ) Less than 1 month

( ) 1-3 months

( ) 4-6 months

( ) 7-12 months

( ) Over 1 year

2. Why did you start attending RRP? (Select all that apply)

[ ] Referred through bail program

[ ] Was homeless

[ ] Referred by school

[ ] Referred by family/friends

[ ] Other: ____

3. Did you access food cupboards in the kitchen while in the residence?

( ) No

( ) Yes

4. Did you access clothing services while in the residence?

( ) No

( ) Yes

5. Were you connected to OW/ODSP for income/rent support?

( ) No

( ) Yes

6. Were you referred to counseling by your Case Manager?

( ) No

( ) Yes

7. How would you rate the Intake Process that you experienced when you first entered the program?

Very bad	1	2	3	4	5	6	7	8	9	10	Very good

8. How would you rate your experience during the process of moving into the residence?

Very bad	1	2	3	4	5	6	7	8	9	10	Very good

9. How would you rate the usefulness of the recreational component of the program to you?

Not at all useful	1	2	3	4	5	6	7	8	9	10	Very much useful

10. How would you rate the usefulness of the life skills training component of the program?

Not at all useful	1	2	3	4	5	6	7	8	9	10	Very much useful

11. Overall, how would you rate the RRP overall?

Very bad	1	2	3	4	5	6	7	8	9	10	Very good

12. Was the program explained well to you before you started?

( ) No

( ) Somewhat

( ) Yes

13. Did you help to set goals and make decisions about your case management plans?

( ) No

( ) Somewhat

( ) Yes

Please explain:

14. How many of your goals were you able to achieve throughout the RRP program?
( ) All of the goals

( ) Most of the goals

( ) Some of the goals

( ) None of the goals

15. Did you complete all the life skills programming set out into your Resident Action Plan (RAP)?
( ) No

( ) Yes

If No, why not? (Select all that apply).

[ ] I was not learning anything/I found it boring

[ ] I did not get along with the other people in the program

[ ] I did not like how the program was run (topics covered, activities, etc.)

[ ] Sessions conflicted with other activities

[ ] Other:

Did you like working with your Case Manager?

( ) No

( ) Somewhat

( ) Yes

Please Explain:

16. Do you feel that your Case Manager respected you?

( ) No

( ) Somewhat

( ) Yes

Please Explain:

_____
_____
_____

17. Do you feel that your Case Manager was professional?
( ) No

( ) Somewhat

( ) Yes

Please Explain:

_____
_____
_____

18. Overall, how helpful has the Social Navigator been in helping you obtain and retain housing in the community?

Not at all helpful	1	2	3	4	5	6	7	8	9	10	Very much helpful

19. In what ways, specifically, would you say the Social Navigator has been <u>helpful</u>?

_____
_____
_____

20. In what ways, specifically, would you say the Social Navigator has been <u>not helpful</u>?

_____
_____
_____

21. Think about your life 6 months prior to your involvement in the RRP and think about how your life is now. How has the RRP changed these areas of your life, if at all?

	Much worse	Worse	No change	Better	Much better	N/A
Family relationships						
Friends						
School/Work						
Outlook on life						
Ability to control my anger and violence						
Better understanding of my culture and other cultures						
Other: _						

22. How much are you involved with the following now, compared to before you started the RRP?

	Much more now	Somewhat more now	No change	Somewhat less now	Much less now	N/A
Using alcohol						
Using cannabis						
Using other drugs						
Involvement with gangs						
Illegal activity						
Police involvement						
Social services						

23. What parts of the program do you believe helped you the most?

24. What parts of the program do you believe were the least helpful or perhaps unhelpful?

25. Would you recommend this program to others?
( ) No

( ) Yes

Why or why not? _____

26. Have you made positive changes in your life because of RRP?
( ) No

( ) Somewhat

( ) Yes

Please explain: _____

27. How can we make the program better?

28. Do you have any other comments?

Appendix K: Client Status Survey

This brief questionnaire will help your Case Manager to keep in touch with how well you are doing to ensure that your needs are being met.

Name:_____ Client ID: _____

Date:

YYYY	MM	DD

1. How well would you say that you are managing life demands now?

Very poorly	1	2	3	4	5	6	7	8	9	10	Very well

Please elaborate on why you rated as you did:

_____
_____
_____

2. How would you rate your current progress toward achieving goals as specified in your Resident Action Plan?

0%	10	20	30	40	50%	60	70	80	90	100%

Anything helping your progress? Anything getting in your way?

_____
_____
_____

3. What could be done to improve your experience in the program at this point?

Appendix L: Attendance/Participation Sheet

Resident Name:				
Case Manager:		Recreational Therapist:		
Event (Specify life skills session or recreation activity)	Date (YYYY/MM/DD)	Life Skills [LS] or Recreation [REC] event	Number of Hours	Comment (Describe programming or

Appendix M: Resident Tracking Sheet

Date (YYYY/MM/DD)	Number of clients in residence	Number clients on waiting list	Number serious occurrence reports	Number clients accessing food bank	Number clients accessing clothing services	Number clients connected to OW/ODSP	Number clients referred to counseling

Appendix N: Social Navigator Activities Sheet

Client ID	Date	Has the client left JHS RRP?		Has the client been housed in the community?		Has the client been re-housed?			Contact			Is the case closed?		Please provide any details regarding progress, updates or outcomes for the client.	Additional Comments
		Yes/No	Date	Yes/No	Date	Yes/No	If yes, how many times?	Date	Frequency of contact	Method of contact	Last contact date	Yes/No	Date		

Appendix O: Recreational Therapist Activities Sheet

Month	Program/Activity	Attendance

Appendix P: Client-Centered Fidelity Checklist

Name: _____ Date: _____

Please rate the level of compliance with each of the following:

	Full compliance	Partial compliance	Limited/no compliance
Assisted clients in clarifying their key values, challenges, and strengths	( )	( )	( )
Allowed clients to drive the process of identifying goals	( )	( )	( )
Identified clients' skills and capacities, existing resources, challenges and supports need to reach short and long-term goals.	( )	( )	( )
Asked motivating questions to prompt clients to determine the best course of action and to take action when ready	( )	( )	( )
Informed clients of resources and opportunities in the community based on the assessment and expressed interests and desires of the client	( )	( )	( )
Helped clients understand the pros and cons of different approaches, and supporting them when they decide how best to meet their goals	( )	( )	( )
Made referrals to services in partnership with clients' motivation and timeline, on the assumption that the client is the expert	( )	( )	( )
Exercised respect, non-judgmental attitudes, attentive listening, and empathy to establish trust and maintain the dignity of the client	( )	( )	( )
Used positive reinforcement and encouragement for achievements.	( )	( )	( )

Appendix Q: Partner Satisfaction Survey

Please complete this brief survey to help evaluate the RRP being run by the John Howard Society of Thunder Bay. The survey is completely anonymous; do not include your name. Your responses will be combined with responses from other partners and stakeholders and will help the Evaluation Team assess the program. No one from the John Howard Society of Thunder Bay will have access to your data, nor will they know who completed the survey. Only the Evaluation Team at the Centre of Research, Policy & Program Development will have access to your information.

Thank you very much. Your sincere feedback is greatly appreciated.

1. I am a...

( ) Landlord
( ) Lawyer
( ) Probation/Parole officer
( ) Police officer
( ) Correctional officer
( ) Community service worker
( ) Community member
( ) Other – Write in: _____

2. How long have you known of the RRP?

( ) Less than 3 months
( ) 4-6 months
( ) 7-12 months
( ) 13-24 months
( ) More than 24 months

3. Rate your current level of overall satisfaction with the RRP?

( ) Very dissatisfied
( ) Dissatisfied
( ) Satisfied
( ) Very satisfied

4. How satisfied are you with the frequency and method of communication between yourself and RRP?

( ) Very dissatisfied
( ) Dissatisfied
( ) Satisfied
( ) Very satisfied

5. How strongly do you agree that your experience with the RRP has been a positive one?

( ) Strongly disagree

( ) Disagree

( ) Agree

( ) Strongly agree

6. Please elaborate

_____
_____
_____
_____

7. From your perspective, what are the best features of the RRP?

_____
_____
_____
_____

8. From your perspective, what are the weakest or most challenging features of the RRP?

_____
_____
_____
_____

9. How did you find out about the RRP? (select all that apply)

[ ] Word of mouth

[ ] At a presentation

[ ] TV or radio

[ ] Newspaper

[ ] Internet

[ ] Email

[ ] Other - Write In: _____

10. How effectively do you feel the program is being promoted/marketed to the appropriate parties?

( ) Not at all effectively

( ) Not too effectively

( ) Effectively

( ) Very effectively

11. Please elaborate

_____
_____
_____
_____

12. How many referrals have you made to the RRP in the past year?
( ) Not in a position to refer
( ) None
( ) 1-5
( ) 6-10
( ) 11-20
( ) 21+

13. If in a position to refer but you made no referral, please explain why

_____
_____
_____
_____

14. If you have made any referrals, how did you find the referral process?
( ) Very difficult
( ) Difficult
( ) Easy
( ) Very easy

15. I would be comfortable bringing an issue to the attention of RRP Program staff?
( ) Strongly disagree
( ) Disagree
( ) Agree
( ) Strongly agree

16. The RRP is an efficient way to have a positive impact on homeless individuals in Thunder Bay
( ) Strongly disagree
( ) Disagree
( ) Agree
( ) Strongly agree

17. RRP staff are a competent group of workers, as a whole
( ) Strongly disagree
( ) Disagree
( ) Agree
( ) Strongly agree

18. Would you recommend this program to potential referring agencies/workers?
( ) No
( ) Yes

19. Please explain

_____
_____
_____
_____

20. How could we improve RRP?

_____
_____
_____
_____

21. Please provide any additional comments on any aspect of this program

_____
_____
_____
_____

Thank you!

Appendix R: Evaluation Tools Checklist

Tool	Who?	When?	Completion – Staff Signature	Date Signed
EVALUATION CONSENT FORM	Case Manager	Following 1-2 week settling in period		
PRE-POST ASSESSMENT	Case Manager	Following 1-2 week settling in period		
	Case Manager	Exit		
	Social Navigator	6 month post-exit		
	Social Navigator	12 month post-exit		
INTAKE FORM	Case Manager	Intake		
SPIN RISK ASSESSMENT	Case Manager	Intake		
	Case Manager	Exit		

	Social Navigator	6-month post-exit		
	Social Navigator	12-month post-exit		
RESIDENT ACTION PLAN (RAP)	Case Manager	Intake		
CLIENT SATISFACTION SURVEY NOTE: PREFERABLY ADMINISTERED ONLINE	Data Entry Assistant	Exit		

7.4. Material Currently in Use by Program

Appendix S: Reintegration Client Eligibility Criteria

Conditions of Eligibility for Services

The John Howard Society (JHS) CRF re-integration services aims to provide assistance and opportunities for individuals to create meaningful and positive changes in their lives and to help ensure a safe and healthy transition back into the community. JHS provides a residential setting offering services to men and women that have served a federal sentence and that are being released to the community. All clients are expected to demonstrate through their behaviours, attitudes, and attendance at required programming that they are actively working towards a crime-free lifestyle.

Admission Criteria

Any person interested in residing at the JHS CRF must complete an application to our facility. The application can be obtained via mail, fax or email. We accept both men and women on Day Parole, on Statutory Release with a Residency condition, on Statutory Release with Voluntary Residency, or that are on Statutory Release without a Residency Condition. The final decision of whether residency will be provided will be made by the JHS Review Committee, after review of the offender's file and after consultation with the local Parole Office, Institutional Parole Officer, and local Police Services.

Eligibility Criteria

1. Be an adult of 18 years of age or older
2. Be order to be under a Parole Supervision Order by the Parole Board of Canada (CSC)

(Day Parole, Statutory Release, Statutory Release with Residency, Statutory Release with Voluntary Residency, Statutory Release)

Individuals who will not be considered eligible include:

1. Individuals who pose immediate risk to the safety of themselves or others
2. Individuals who have had a serious suicide attempt within the last 6 months
3. Individuals who are currently actively abusing substances and do not desire to stop
4. Individuals who are incompatible with a client already residing at the JHS
5. Individuals who are not to be in communication (non-contact/non-association order) with a client already residing at the JHS
6. Individuals who refuse to sign the 'Rules of Residency'
7. Individuals who require a high level of supervision for violent or inappropriate behavior
8. Individuals who have high needs around mental health issues and refuse to engage in treatment or supportive services
9. Individuals that demonstrate major problematic behavioural issues within the institution consistently throughout their incarceration
10. Individuals that demonstrate behaviour that could cause harm towards CRF staff, other CRF residents and the community

Appendix T: Intake Form

Date: _____ Interviewer: _____ Location: _____

Client Confidentiality Policy

Our policy on confidentiality is intended to create an atmosphere in which you can use our service(s) without fear of the information discussed being disclosed to others. In providing service(s) to you, the need may arise for us to share information with others as it relates to helping you achieve your goal(s). No information will be shared outside the agency without your written consent, EXCEPT for the following Limitations to Confidentiality as outlined below:

Acknowledgement of Limitations to Confidentiality

All information gathered and held by the John Howard Society of Thunder Bay and District regarding an individual is confidential except when:

1. A danger to the community or individual exists (Threats to harm self or others; duty to report child abuse or neglect, or suspected child abuse or neglect)
2. Where failure to disclose the information will cause greater harm than the disclosure of the information
3. Where there is a legal responsibility to disclose information
   (a) Disclosure of information regarding current court case and legal process

   I fully understand that anything I say will be documented in case notes kept by the Bail Verification and Supervision Program. I therefore understand that there is a possibility that the case notes kept may be subpoenaed and presented as evidence in court which may or may not be used against me. I understand that I have the right not to disclose any information and what might happen should I disclose information.

   Client Initial: _____

4. Permission from the client has been received, preferably in writing, to disclose information
5. Where public refutation of statements made by, or on behalf of, a client is required to protect the integrity of the agency

SHOULD ONE OF THE ABOVE EXCEPTIONS BE INVOKED, ONLY THE REQUIRED INFORMATION WILL BE DISCLOSED.

Upon my written consent, I hereby authorize the John Howard Society of Thunder Bay and District to obtain and compile any relevant information that might be helpful in the provision of service(s) or to exchange relevant information with appropriate social, educational, psychological, medical and/or legal authorities.

Client Name: _____

Client Signature: X _____ Date: _____

Staff Signature: X _____ Date: _____

Biographical Information

SURNAME **GIVEN NAME**	
GENDER	**What gender do you identify with?** ( ) Male ( ) Female ( ) Transgender male ( ) Transgender female ( ) Self-identify as: _____ ( ) Prefer not to answer
ALIASES	
DATE OF BIRTH	**YEAR: _____ MONTH: _____ DATE: _____**

BACKGROUND	**What ethnicity do you identify with?** ( ) White ( ) Hispanic or Latino ( ) Black or African Canadian ( ) Indigenous or First Nation ( ) Asian / Pacific Islander ( ) Other - Write In: _____ **If First Nations, Indigenous, Metis or Inuit: Do you have Status?** ( ) No ( ) Yes **If Yes, do you have a Status Card?** ( ) No ( ) Yes **If No, do you plan to get a new Status Card?** ( ) No ( ) Yes **What do you need to do to get it?** _____ _____ **What Band are you with? What community is your family from?** _____ *Continued on next page…*

Referral and Previous Involvement With JHS

REFERRAL DATE	
REFERRAL SOURCE	**What was the referral source?** ( ) Lawyer ( ) Duty counsel ( ) Social worker ( ) Outside agency ( ) Other - Write In: _____ Are you a Bail Verification and Supervision Program client? ( ) No ( ) Yes

	( ) Don't know
COURT DATE(s) W/ LOCATIONS	**Date: _____ Location: _____** **Date: _____ Location: _____** **Date: _____ Location: _____** **Date: _____ Location: _____**
FORMER CLIENT	**How were you previously involved with JHS? (Program and dates; how did the involvement end?)** _____ _____

Criminal History

AGE AT FIRST ARREST	**(including youth) regardless of whether a conviction/disposition resulted. Include type of offense.** _____
ACCEPTS RESPONSIBILITY ***(Do not ask if applying for BSVP)***	**Tell me a little bit about the situation in which your first arrest took place? (Arrested)** _____ _____ _____ *Continued on next page…*

CURRENT CHARGES	**PENDING CHARGES**	**PREVIOUS ADULT CONVICTIONS**
_____ _____ _____ _____	_____ _____ _____ _____	*(Capture variety of offences: Assault/Violence; Robbery; Break & Entre; Fraud; Other Property; Drug; Impaired; Sex Offences; etc.)*

INCARCERATIONS AS AN ADULT	**Any incarcerations as an adult?** ( ) No ( ) Yes **If Yes, where were you incarcerated? How long were you incarcerated?** _____ _____ **If Yes, any institutional charges or occurrences?** ( ) No ( ) Yes **If so, what were the nature of these institutional charges or occurrences?** _____ _____ _____
INCARCERATIONS AS A YOUTH	**Incarcerations as youth?** ( ) No ( ) Yes **Open or secure custody?** ( ) Open ( ) Secure ( ) Don't know
CONTACT RESTRICTIONS	**Non-Contacts:** _____ **Incompatibles:**

	_____ _____

Response to Supervision

FAILURE TO APPEAR IN COURT	**Have you ever had a fail to appear in court?** ( ) No ( ) Yes **How many times?** ( ) Once ( ) 2 times ( ) 3 times ( ) 4 or more times
TECHNICAL VIOLATIONS OR BREACHES OF CONDITIONS OF SUPERVISION	**Have you ever breached conditions while on supervision or probation/parole?** ( ) No ( ) Yes **If Yes, which conditions were breached?** _____ _____ **Have you ever re-offended while on supervision in the community?** ( ) No ( ) Yes **What was the charge?** _____
EVER ESCAPED OR ATTEMPTED ESCAPE	**Have you ever attempted to escape or escaped jail?** ( ) No ( ) Yes **If Yes, when and what institution?** _____ _____ *Continued on next page…*

Aggression/Violence

VIOLENT BEHAVIOUR	**Has there been any violent behaviour recently or in your adult life (regardless of charges being laid. Ex: Bar fights, fights while incarcerated, etc.)?** ( ) No ( ) Yes **If Yes, please describe with whom and the nature of the violent behaviour** _____ _____ **Do you have a history of physical fights?** ( ) No ( ) Yes
ANY VIOLENCE TOWARD UNKNOWN VICTIMS ***(Do not ask if only alleged and applying for BVSP)***	**Have you ever had violent encounters with someone you did not know?** ( ) No ( ) Yes **Do you have a history of physical fights toward unknown victims?** ( ) No ( ) Yes **If Yes, what was the circumstance(s) that violence occurred?** _____ _____ _____
PERPETRATOR OF DOMESTIC VIOLENCE ***(Do not ask if only alleged and applying for BVSP)***	**If Yes was it towards one partner?** ( ) No ( ) Yes **Have there been multiple relationships that have involved domestic violence?** ( ) No ( ) Yes **What was the circumstance(s) that led to violence?**

	_____ _____
VIOLATIONS OF PROTECTION OR NO CONTACT ORDERS ***(Do not ask if only alleged and applying for BVSP)***	**If Yes, with who was the violation towards? How long ago did it occur? How many times have violations of no contact orders occurred?** _____ _____

Substance use

ALCOHOL AND DRUG USE	**Were you intoxicated or under the influence of alcohol or drugs at the time of your arrest?** ( ) No ( ) Yes
(Do not ask if only alleged and applying for BVSP)	**Were you under the influence of alcohol or drugs during the time of the incident?** ( ) No ( ) Yes

TYPE OF SUBSTANCE	EVER USED	DAILY	3-6 DAYS/ WEEK	1-2 DAYS/ WEEK	FEWER	NONE	AGE AT 1ST USE	USE DISRUPTS FUNCTION-ING	USE CONTRIBUTES TO CRIMINAL BEHAVIOUR	INDICATION OF USE WHILE IN CUSTODY	TRIES TO CUT BACK
Alcohol	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐
Cannabis	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐
Cocaine	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐
Crack	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐
Ecstasy	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐
MDMA	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐
Heroin	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐
Fentanyl	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐
LSD/Acid	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐
Inhalants/Solvents	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐
Amphetamines (ex: speed)	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐
Meth	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐
Prescription Drug misuse	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐

	Do you think you have a problem with alcohol or drugs? ( ) No ( ) Yes **If yes, what is problematic about your usage of alcohol or drugs?** _____ _____ **What would you change about how you use drugs and alcohol?** _____ _____ **Have you attended treatment before?** ( ) No ( ) Yes **If yes, when did you attend treatment?** _____ **If yes, did you complete the treatment?** ( ) No ( ) Yes **What, if anything, was helpful about attending treatment?** _____ **Are you interested in addressing any issues with alcohol or drugs? (ex: attend treatment, attend community programs, attending AA/NA meetings, work with an addictions counsellor, etc.)** [ ] Attending treatment [ ] Attending community programs [ ] Attending AA/NA meetings [ ] Work with addictions counselor [ ] Other - Write In: _____

Social Influences

GANG ASSOCIATION	**Do you currently belong to a gang?** ( ) No

	( ) Yes **Have you ever belonged to a gang?** ( ) No ( ) Yes **Which one? _____** **How long ago were you involved with a gang?** ( ) Less than 1 year ago ( ) 1-2 years ago ( ) 3-4 years ago ( ) At least 5 years ago **Do you associate with people who are in a gang?** ( ) No ( ) Yes **Do/Did any of your family members belong/belonged to a gang?** ( ) No ( ) Yes **If Yes, who in your family belongs/belonged to a gang?** _____ _____
PEER RELATIONSHIPS	**Who do you see as a positive support in the community? How are they a positive support to you?** _____ **Who do you see as a negative influence within your group of friends? What types of things might lead you to trouble?** _____

Family

RELATIONSHIP STATUS **(INTIMATE RELATIONSHIP AND MARITAL RISK FACTOR)**	**Are you currently in a relationship with anyone? (ex: dating, common-law, married, divorced; recently separated)** ( ) Dating ( ) Married ( ) Single ( ) Divorced ( ) Common law

	( ) Widowed ( ) Other - Write In: _____ **How long have you been in the relationship for?** ( ) Less than 1 year ( ) 1-2 years ( ) 3-4 years ( ) 5-7 years ( ) 8 years or more **How well do you get along with each other? (ex: do you argue often? Do you break up and make up? Have there been any instances of domestic violence?)** ( ) Very poorly ( ) Poorly ( ) So-so ( ) Well ( ) Very well _____ _____
FAMILY OF ORIGIN	**(Ask about the relationship with each; is it positive? Are they supportive? Do they still communicate? Etc. Ask for names and ages)** **Where did you grow up?** _____ _____ **With whom did you grow up?** _____ _____ **What was growing up like for you? (ex: Absent parent(s); violence among caregivers; kicked-out of home; foster care; etc.)** _____ _____ _____
Gather bio details (name, age) and status of relationship (how would	Mother: _____

they describe it? Do they communicate often?	Father**:** _____ **Brother(s):** _____ **Sister(s):** _____ **Grandparent(s):** _____
ATTACHMENT TO CHILDREN	**Do you have any children?** ( ) No ( ) Yes **If yes, how many?** ( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) More than 4 **What are their names? How old are they?** _____ **Who has custody? Where do they live?** _____ **Are you allowed to see your children?** ( ) No ( ) Yes **If Yes, how often do you see your children?** ( ) Every day ( ) Once per week ( ) Every other week ( ) Once per month ( ) Every other month ( ) Other - Write In: _____

	If No, why are you not allowed to see your children? _____ _____ *Continued on next page…*

Employment, Education, and Income

CURRENT STATUS	**Are you currently employed?** ( ) No ( ) Yes **Who do you work for?** _____ **Full or part-time?** ( ) Full-time ( ) Part-time ( ) Other - Write In: _____ **Have you ever been fired from a job?** ( ) No ( ) Yes **If Yes, how many times?** ( ) Once ( ) 2 times ( ) 3 times ( ) 4 or more times
FUTURE EMPLOYMENT	**What are your plans for future employment?** _____ _____
EDUCATION	**What is the highest grade that you have completed?** ( ) 4 ( ) 5 ( ) 6 ( ) 7 ( ) 8 ( ) 9

	( ) 10 ( ) 11 ( ) 12 ( ) 13 ( ) College ( ) University ( ) Other - Write In _____ **Do you have any certifications or have taken any specific training?** ( ) No ( ) Yes **If Yes, please specify:** _____ **Do you have any plans to complete or continue with education?** _____
INCOME SOURCE (STABILITY)	**How do you financially support yourself?** _____ **Are you currently eligible for OW or ODSP?** ( ) No ( ) Yes ( ) Don't Know **Who is your case worker?** _____ **Do you have an Ontario Health Card?** ( ) No ( ) Yes ( ) Don't know **Do you have a Social Insurance Number?** ( ) No ( ) Yes ( ) Don't know **Do you have a Birth Certificate?**

	( ) No ( ) Yes ( ) Don't know

Social/Cognitive Skills

IMPULSIVITY	**What triggers your anger?** _____ _____ **What triggers any substance use?** _____ _____ **What type of coping strategies do you use when you are experiencing negative emotions like frustration, anger, sadness, grief?** _____ _____
HOSTILE ATTRIBUTIONS	**How well do you get along with others?** ( ) Very poorly ( ) Poorly ( ) So-so ( ) Well ( ) Very well **Are you able to handle dorm style accommodations (*shared showers, kitchen, common areas*)*?*** ( ) No ( ) Yes ( ) Don't know

Mental Health

MENTAL HEALTH CONDITION	**Have you ever been diagnosed with a Mental Health Disorder?** ( ) No ( ) Yes ( ) Don't know **If Yes, what is the diagnosis? When were you diagnosed?** _____

	____ **Are you currently working with a Psychiatrist of Mental Health worker?** ( ) No ( ) Yes **If No, have you experienced any symptoms of a mental health disorder? (ex: Anxiety, Depression, Hearing Voices, Hallucinations, Panic, etc.)** _____ ____ _____ ____
TYPE OF CONDITION(S)	**If you have been diagnosed with a mental health disorder, what was the diagnosis? Check all that apply** [ ] Depression or other affective disorder [ ] Anxiety disorder [ ] Psychoses [ ] Schizophrenia [ ] Bipolar disorder [ ] Thought, personality and adjustment disorders [ ] Other - Write In: _____ **If Yes, when were you diagnosed?** _____ **Do you believe that you have emotional/mental symptoms that have not been diagnosed?** ( ) No ( ) Yes **If Yes, for how long have you been experiencing these symptoms?** ( ) Less than a month ( ) 1 to 6 months ( ) 7 months to 1 year ( ) 2 to 3 years ( ) 4 to 5 years ( ) 6 to 7 years ( ) 8 years or more
MEDICATION(S)	**Are you taking any medication(s)?** ( ) No

	( ) Yes **If Yes, what are they?** _____ _____ **What do they help you with?** _____ _____ **How long have you had a prescription or have been taking these medications?** ( ) Less than 6 months ( ) 7 months to 1 year ( ) 1 to 2 years ( ) 3 to 4 years ( ) 5 to 6 years ( ) 7 years or more **Have you stopped taking any medications over the last year?** ( ) No ( ) Yes **If Yes, what led to you not taking them anymore?** _____ _____
HOMICIDAL IDEATION	**Have you ever had thoughts to seriously harm another person? (Ex: when frustrated or mad)** ( ) No ( ) Yes **Have you ever tried to seriously hurt another person intentionally or by accident?**

	( ) No ( ) Yes
SELF HARM	**Have you ever engaged in deliberate self-harming behaviour?** ( ) No ( ) Yes **What did you do to hurt yourself?** _____ _____ **How often did you hurt yourself?** _____ _____ **When was the last time you hurt yourself?** _____ _____ **What are/were some of your triggers that led you to hurting yourself?** _____ _____ _____ _____
SUICIDAL IDEATION	**Have you ever thought of killing yourself or dying by suicide?** ( ) No ( ) Yes **If Yes, when was the last time you thought about killing yourself or dying by suicide?** ( ) Within a month ago ( ) 1-3 months ago ( ) 4-6 months ago ( ) 7 months to 1 year ago ( ) 1 to 3 years ago ( ) 4 or more years ago ( ) Can't remember **Have you ever attempted to kill yourself or die by suicide?** ( ) No ( ) Yes **If Yes, when was the last time you tried to kill yourself? What was your method?** _____ _____

	_____ _____ **If in custody, were you put on suicide watch while incarcerated?** ( ) No ( ) Yes ( ) Not applicable **If Yes, how long were you on suicide watch for?** _____ _____

General Health

PHYSICAL HEALTH	**Do you have any health problems or concerns? (Allergies, Viruses, Physical Disabilities, communicable diseases, etc.)** [ ] Allergies [ ] Physical disability [ ] Communicable disease [ ] Diabetes [ ] Asthma or other lung condition [ ] Mobility issues [ ] Other - Write In: _____ **Are you a carrier of any communicable diseases?** ( ) No ( ) Yes **If so, what are they?** _____ **Do you have a family Doctor or Nurse Practitioner?** ( ) No ( ) Yes **What clinic do you go to most?** _____ _____ _____ _____

ATTITUDE	**Tell me about why you want to take part in the program at John Howard Society? (BVSP, Residential, etc.)?** _____ _____ _____ _____ _____ _____

Bail Verification & Supervision Program

ABILITY TO COMPREHEND	**What is your understanding of the Bail program and what is expected of you?** _____ _____ _____ _____ **How well do you understand the court process?** ( ) Not at all ( ) A little bit ( ) Quite well ( ) Very well **Do you know what 'conditions' are?** ( ) No ( ) Yes **What are some conditions that you expect to have to follow if released to the Bail Program?** _____ _____ _____ _____ **What do you think will happen if you are not able to report as directed or follow all of the conditions imposed by the court?** _____ _____ _____ _____

Living Situation

ACCOMODATION & COMMUNITY SUPPORT	**Street address including city; how long have they been living there?** _____ _ _____ _ **What is your current living accommodations?** ( ) House ( ) Apartment ( ) Residential facility ( ) Shelter ( ) Couch surfing ( ) Other - Write In: _____ **How long have you lived there?** ( ) Less than 1 month ( ) 2 to 6 months ( ) 7 to 12 months ( ) 1 to 3 years ( ) 4 to 6 years ( ) At least 6 years **Is there an address/place that you can go to if you are unable to return to your current address?** _____ _____ **Is there someone who could support your and be your Surety?** ( ) No ( ) Yes ( ) Don't know **If Yes, NAME: _____ PHONE NUMBER: _____** **RELATIONSHIP: _____** **How many times have you moved over the last year?** ( ) Never ( ) Once ( ) 2 times ( ) 3-4 times ( ) 5-6 times ( ) 7 times or more

	Have you experienced any homelessness in the last year? ( ) No ( ) Yes **If Yes, how many times over the last year have you experienced homelessness?** ( ) Once ( ) 2 times ( ) 3 times ( ) 4 times ( ) 5 times or more **If Yes, for how long were you homeless most recently?** ( ) Less than 1 week ( ) 1 to 2 weeks ( ) 3 to 4 weeks ( ) 1-2 months ( ) 3-4 months ( ) 5-6 months ( ) 7-8 months ( ) 9 months or longer

In General

On a scale of 1 to 10 (1 = worst, 10 = best), circle the number indicating how you are currently doing in general/overall.

1 2 3 4 5 6 7 8 9 10

On a scale of 1 to 10 (1 = terrible, 10 = very good), circle the number indicating how you would rate your ability to cope with your current stress level?

1 2 3 4 5 6 7 8 9 10

CURRENT CONTACT INFORMATION:

Additional Information/Notes

Age:

Former client: Y N

Gender: M F X

Aboriginal: Y N

MH: Y N

SU: Y N

Class of Offence: 1 2 3

Appendix V: Resident Action Plan (RAP)

Goal 1	Action Steps	Additional Services	Begin:	Completion:
Goal statement (ensure to follow SMART)				
Relative to SPin?				
Resources required; desired outcomes; noted barriers				

Goal 2	Action Steps	Additional Services	Begin:	Completion:
Goal statement (ensure to follow SMART)				
Relative to SPin?				
Resources required; desired outcomes; noted barriers				

Goal 3	Action Steps	Additional Services	Begin:	Completion:
Goal statement (ensure to follow SMART) Relative to SPin?				
Resources required; desired outcomes; noted barriers				

Client: _____ **Room #**_____ **Date:** _____

Your resident action plan is an opportunity for you to identify goals that you would like to work on while transitioning through the John Howard Society in partnership with your case manager. Goals should be relevant to you needs and designed to align with the purpose of the John Howard Society; to foster genuinely safer communities. Once a SPin assessment has been completed with you and your case manager, the assessment can be used in discussion with development of the resident action plan. Ensure goals are SMART (Specific, Measurable, Attainable, Realistic, and Timely). You should be provided with a copy of your action plan.

Staff Signature: _____ Date: _____

Client Signature: _____ Date: _____

Effective.
Just.
Humane.

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