Supported Referrals

Program Evaluation Report prepared for Homeward Trust Edmonton

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TURNER | STRATEGIES

CONTENTS

Summary of Findings 3

Background & Program Overview 10

Agency & Client Interviews 15

Supported Referrals Data Analysis 27

Supported Referrals, Rapid Rehousing & Housing First Intensive Case Management Program Comparison 33

Costs Analysis 43

Appendix 1: Joined Up Data Set 45

SUMMARY OF FINDINGS

BACKGROUND

Homeward Trust Edmonton (HTE) is a community-based System Planning Organization that provides leadership and resources towards ending homelessness in Edmonton. In 2017, HTE launched the Supported Referral (SR) pilot program targeting individuals and families experiencing homelessness in partnership with 10 service providers.

The SR program providers financial resources and furnishings to support service agencies to help their clients to access housing. The SR model represents an upstream approach that aims to prevent chronic homelessness that expands the network of partners that can achieve housing for people, and supply supports to help them avoid a return to homelessness.

Evaluation Objectives

HTE engaged Turner Strategies as an independent external evaluator to conduct an analysis of the emerging data from the Supported Referrals project. The evaluation sought to assess the effectiveness and cost-efficiency of the project in achieving housing outcome. To assess impact against other models, the SR's stream was compared against Rapid Rehousing (RRH) programming offered by two providers.

This interim report provides an overview of emerging findings from the initial quantitative analysis. It will also be important to assess the experience of agencies and clients participating in the initiative in order to continue improving the Supported Referral approach - as such, interviews with SR providers (n=9) are commencing building on these findings.

Methods

ETO data sets from Supported Referral (n=109), RRH (n=25), and Housing First (n=166) from April 2017 to March 2018 were provided to the evaluator by Homeward Trust staff. These data sets were combined and analyzed in Google Sheets using available qualitative/quantitative variables. Correlation coefficients and p-values were generated for the Supported Referral data set on its own, and then in comparison with the RRH data set.

Financial information for actuals submitted by program staff were submitted to the evaluator by HT staff for both groups. The RRH programs had data from April 2016 to March 2017, and from April 2017 to January 2018. Supported Referral program financial data was dated from April 2017 to March 2018. This data was analysed to generate analysis comparing the financial information between the two program types.

Semi-structured interviews were conducted with SR agency staff (n=9) and clients (n=4) to complement the quantitative data analysis.

INTERVIEW SUMMARY

From the **service provider** perspective, several key learnings emerged from implementation:

- A relationship with the client supports SR staff having a better assessment to determine readiness and success for SR.
- Access to flexible funds has provided agencies working with vulnerable groups an effective resource to support their clients in accessing housing.
- SR fills a critical gap for lower acuity/hidden homeless individuals and families who would otherwise not be able to access Housing First programming.
- There is a particular benefit for lone female parents (pregnant or parenting) evident in the program's capacity to support this population segment.
- The bounds in the eligibility criteria provide adequate flexibility for diverse agencies to tap into the SR model to increase their impact on housing.

From a **system planner** perspective, HTE considerations include:

- The model allows HTE to leverage existing system resources, mainly the staffing complement of diverse funded and non-funded agencies, and focuses these on housing through the SR funds.
- This provides a low-cost strategy for HTE to achieve its broader mandate in homelessness prevention without having to fund staffing per se. Of note, these staff are still part of the system and are funded by other ministries/funder in the community – as such they are not a net zero cost.
- Of note, SR supports to clients are not a 'light touch': in practice, both agencies and clients reported being supported beyond six months and, given the notable needs reported, supports were intensive to build trust/rapport, secure housing, and system navigation.
- The staff effort is confirmed by the client-reported impact of the service beyond housing: participants noted they had an increase in confidence, the ability to deal with health issues, gained employment, were more hopeful, and/or had social connection as examples of qualitative indicators of success. Clients pointed to the staff relationship as critical to feeling supported.

From a **client standpoint**, respondents were very positive about the support received from SR staff and the access to flexible funds to support housing. Quotes highlight the value-add beyond the immediate support for housing:

It saved my life, I'm an ex-addict…they gave me rent and a damage deposit. It got me out of the neighbourhood where I use to work [sex trade] and use in – it gave me a new start – not only just being clean, but clean in a new home.

This made a huge difference for me – I would have been without a steady place. My baby is born now, and we are settled in my place.

It was a blessing – I love everything – it offers opportunities to people that they didn't have…My life would have been different without it. The housing has helped me stabilize – anxiety, depression…and given me a good start.

QUANTITATIVE ANALYSIS KEY FINDINGS

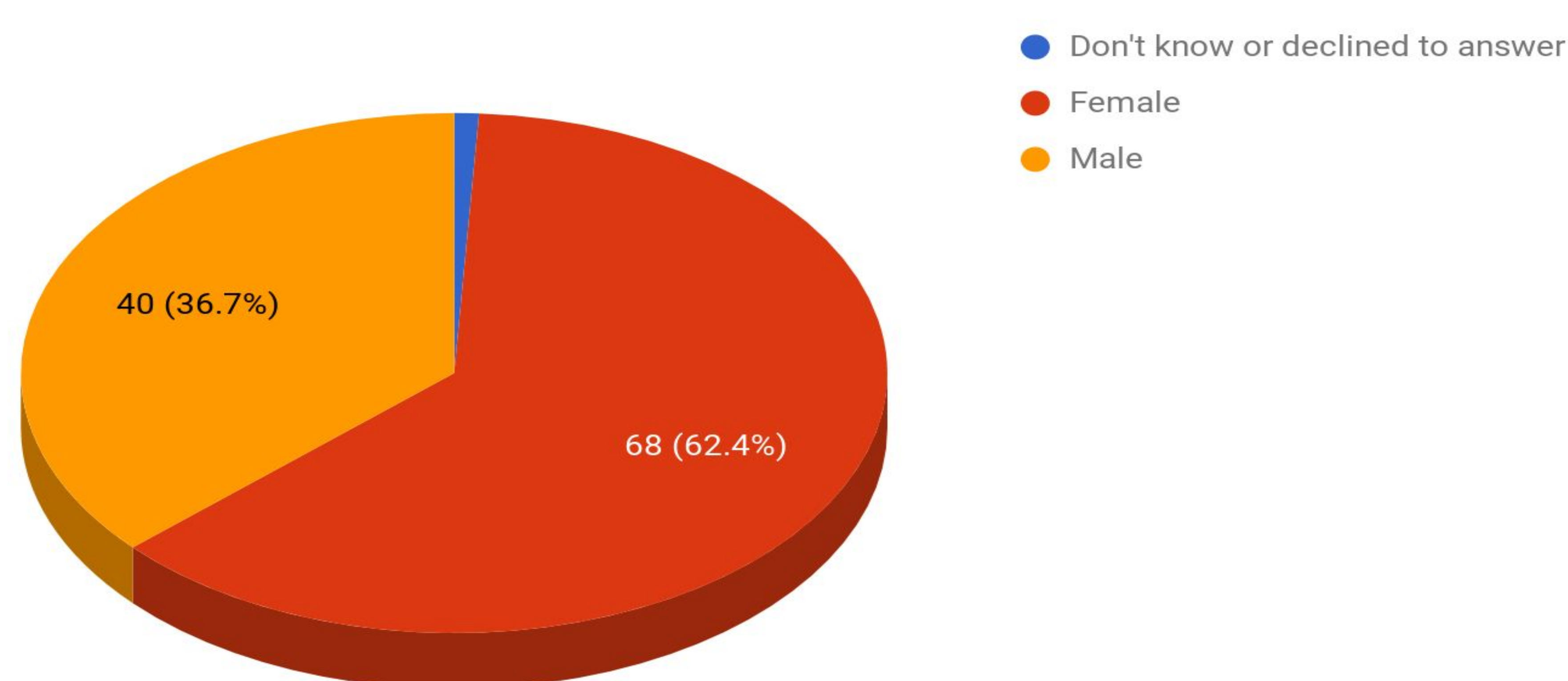
A number of key findings shed further light on SR program participants from the quantitative data analyzed.

Supported Referrals Sample Analysis (n=109)

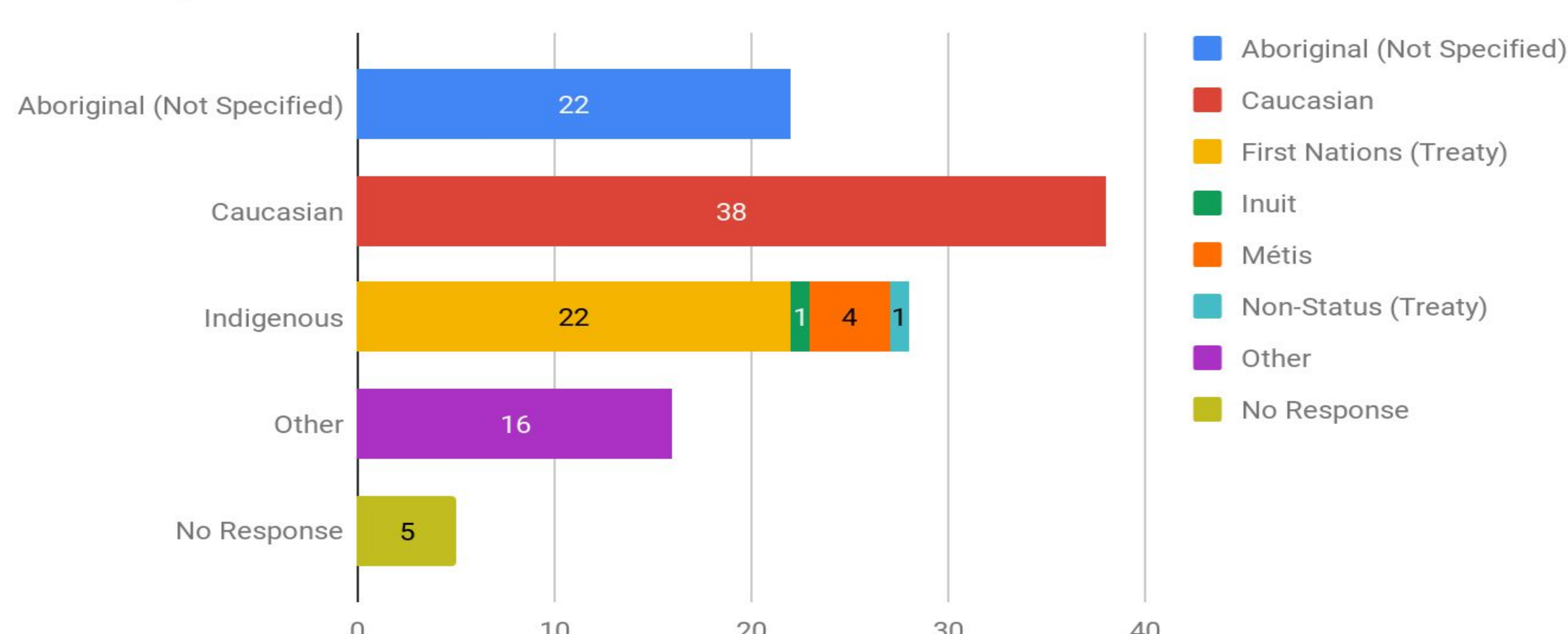
- Average age in the sample was **41 years old**, with **107 months homeless** and **2.4 episodes** in the past year. Most were **couchsurfing (50%)**, in shelters (22%) and other locations (23%) at assessment; only **5% were outdoors.** Average **VI-SPDAT score was 7**. This aligns with eligibility criteria of the program focused on shorter homelessness periods and lower acuities.
- Average numbers of days was 113 – almost **four months**, though program is relatively new.
- Majority were **females (62%)** compared to males (37%); average of **0.8 dependents** per client. This aligns with expectations from programs focusing on lower acuity populations likelier to be families.
- Ethnicity of clients was: 35% Caucasian, 58% Indigenous and 15% Other (presumably immigrants or visible minorities); the balance were No Responses.

Significant Relations among Supported Referral Variables

- Men tended to be **older** than women; women were likelier to have **dependents**.
- Proportion of men is higher for the **Caucasian** group comparing to other groups.
- Bissell Centre had **more men** clients, whereas CEASE, CSS, E4C and IAAW had **more women**; all IAAW and CSS clients had dependents. Pregnancy Pathways had **younger** clients; HIV Edmonton had **older** clients. This aligns with focus among these provides on key populations.
- CSS clients had assessments only in **shelters**, while CEASE had only couchsurfing. It is unclear if this is intentional and will need confirmation in interviews.
- Average **acuity scores differed** among the 10 organizations; it should be explored further to assess whether this is a result of training and operationalizing the assessment, or actual acuity differences.



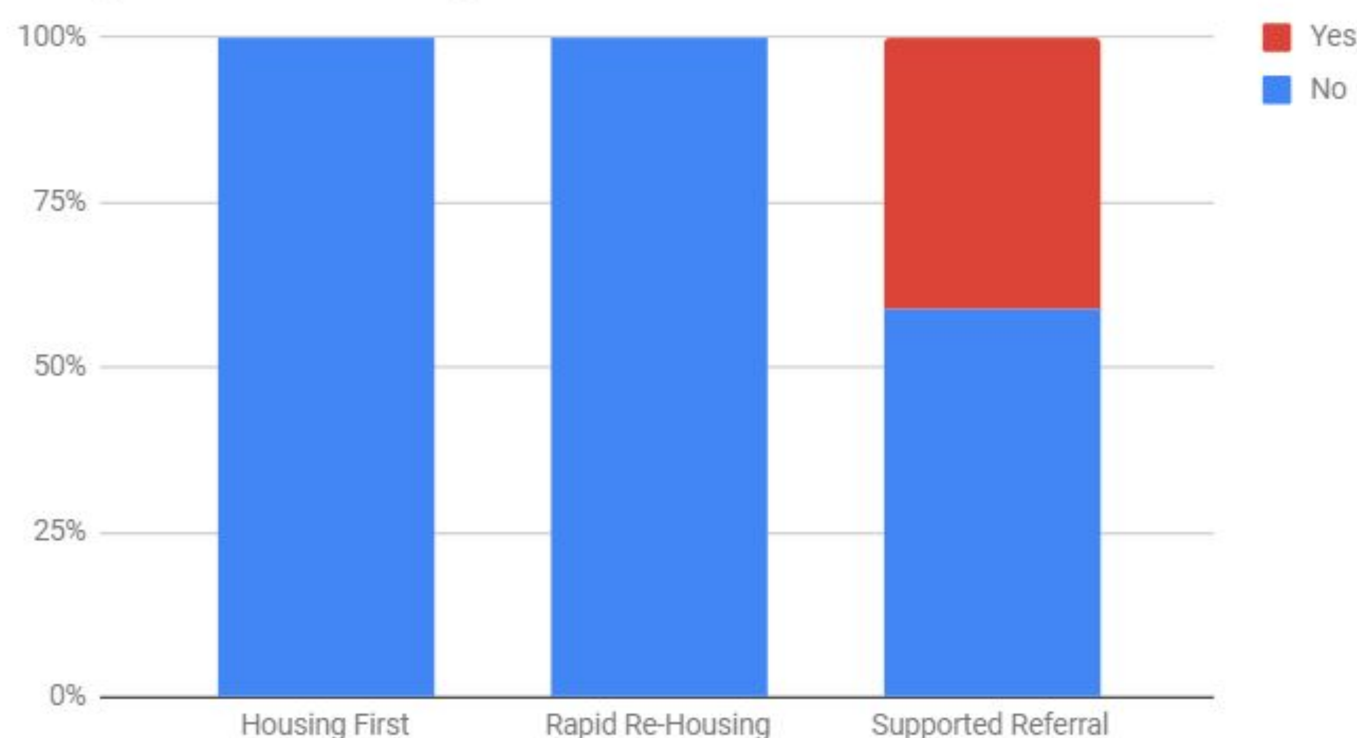
The majority of program participants in SR were females (62%) compared to males (37%).



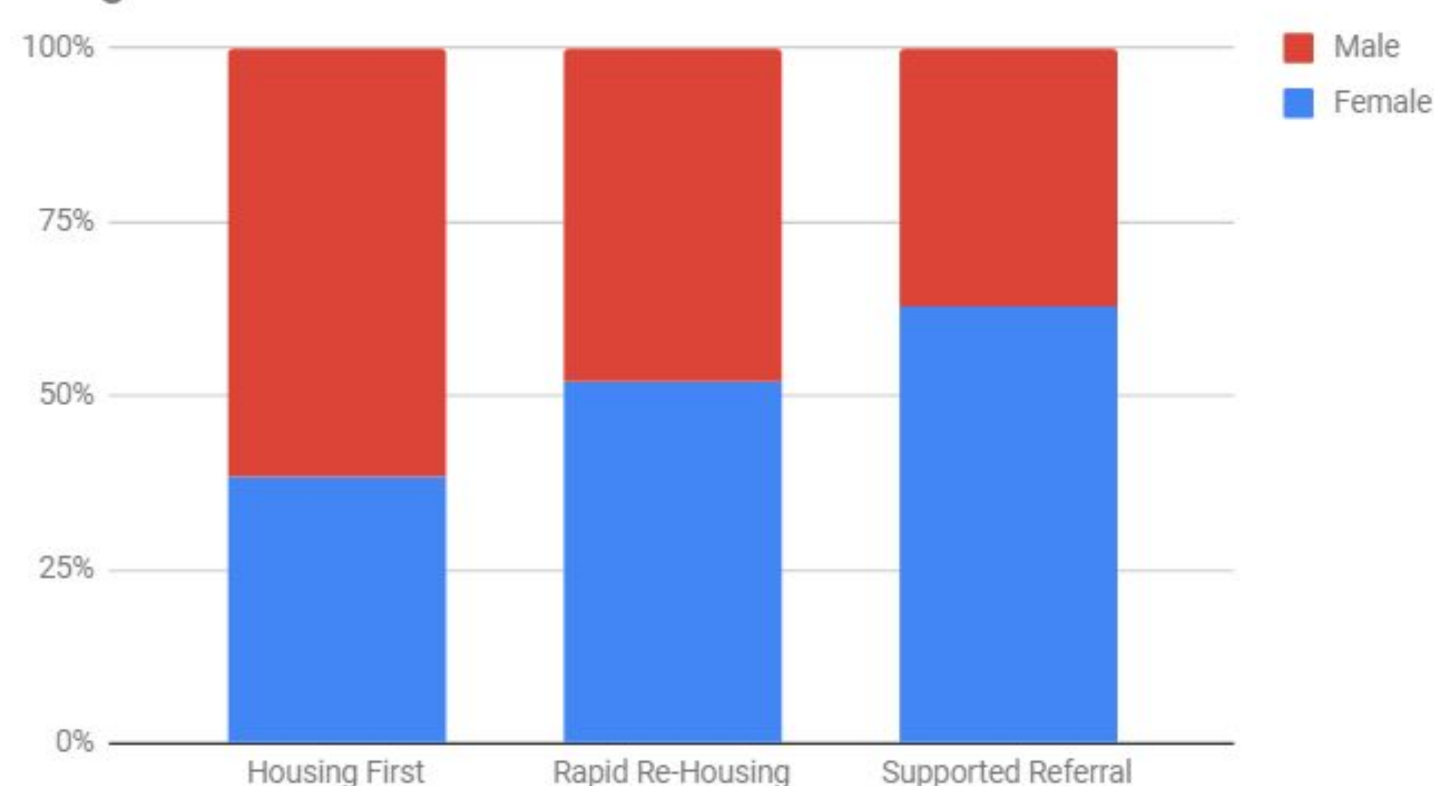
The self-reported ethnicity of most clients was 35% Caucasian, 20% First Nations (Treaty), 20% Aboriginal, and 15% Other (presumably immigrants or visible minorities). The balance were Metis, Non-Status Treaty, Inuit, and No Responses.

PROGRAM TYPE ANALYSIS

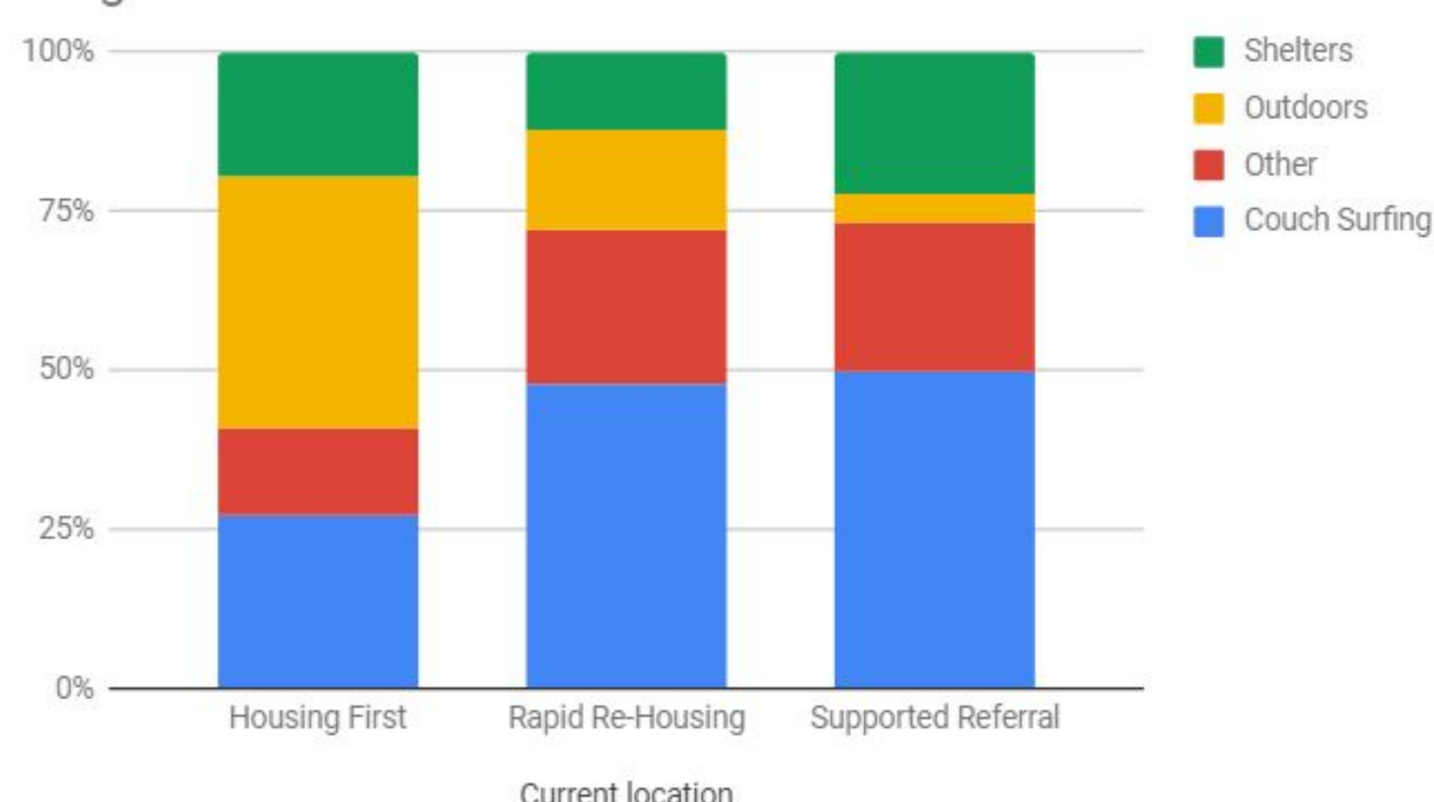
- SR clients have **lower acuity** scores than RRH and HF clients.
- SR clients are **waiting less time** between intake and housing than RRH and HF clients. To contextualize this, SR agencies locate housing for an individual; once housing has been secured, individuals are entered into ETO ("intake") and will soon move into the house. The housing process is therefore shorter from a data visibility perspective. SR participants are not eligible for HF programs, and by going through the SR process they do not enter the Coordinated Access system – a point to try to ensure efficient CA time use.
- SR clients have lower acuity scores than RRH and HF clients.
- More SR clients are **female** compared to RRH and HF.
- More SR clients come from **shelters and couchsurfing** compared to RRH and HF. Fewer come from outdoors.
- SR clients have **dependents**; RRH and HF clients do not.
- SR clients are **younger** than RRH and HF clients.
- The range of SR client **days in program spans longer** than that of RRH clients, but fewer than HF clients. This is a programmatic difference as RRH is a three-month program, ICM is a 12-month program, and SR is a six-month program.



SR clients have dependents; RRH and HF clients do not.



More SR clients are female compared to RRH and HF.



More SR clients come from shelters and couch surfing compared to RRH and HF. Fewer come from outdoors.

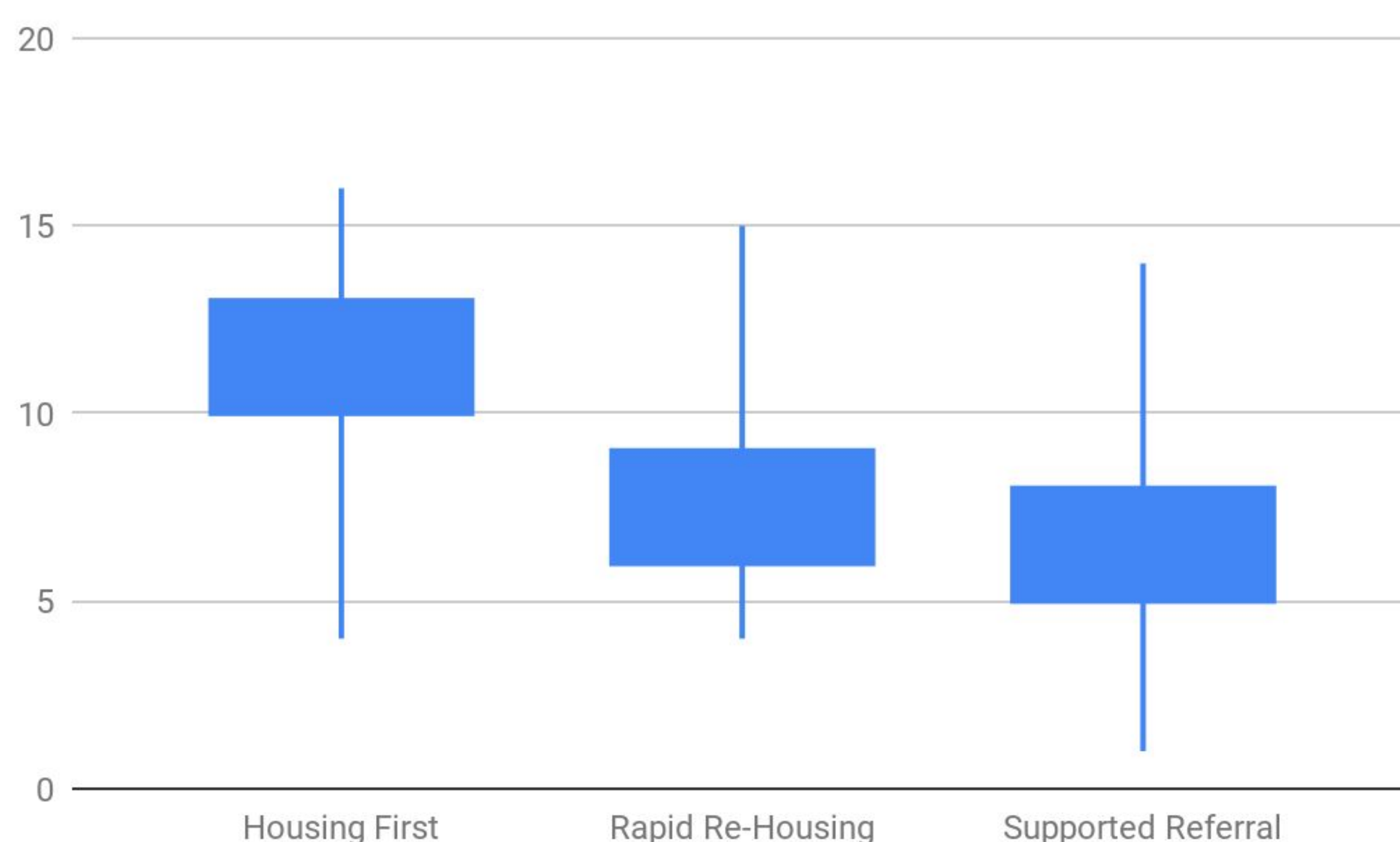
NOTABLE DIFFERENCES AMONG PROGRAM TYPES

Whereas RRH (like ICM/Housing First) reporting does include information on successful/unsuccessful exits from program, the Supported Referral project does not. The SR participants are never in a program per se – the agencies report on their continued service provision to recipients of SR funding and report monthly on the status of housing for each supported referral for the first six months after housing. Following that, agencies are no longer required to report on SR participants' housing status, so SR participants never enter or exit a separate program – rather, the agency continues to provide the support services it would otherwise have done, although now they are doing so with a client housed through SR. The SR reporting period ends at six months.

Intake to Housing: When comparing the time from Intake to Housing across the program types, SR clients waited less time than those in RRH and HF programs; however, there was a small percent of clients who 'trailed' from 150-390 days in the SR sample compared to RRH and HF. The natural drop-off for SR seems to be 60 days, after which 4% or less of clients are waiting for up to 390 days. This drop-off occurs at 150 days for RRH, and 180 days for HF programs.

Days in Program: SR clients are staying in the programs longer than RRH, but less than HF clients during the initial three months:
- at 30 days, 100% of SR clients were still enrolled, compared to 100% for RRH and 96% in HF;
- at 60 days, 93% of SR clients were still enrolled, compared to 96% for RRH and 93% in HF;
- at 90 days, 75% of SR clients were still enrolled, compared to 84% for RRH and 89% in HF; SR seems to be lower at the end of three months.

Of note, at 180 days, RRH has a drop-off with only 8% of clients remaining in the program vs. 26% for SR and 42% for HF. The longest time reported in the sample for SR was 270 days at 2.4%, compared to 0 in RRH and 6% in HF. This drop of for RRH is expected as the program is designed as a three-month intervention, while HF/ICM is intended for one year.



SR clients have lower acuity scores than RRH and HF clients.

COSTS ANALYSIS

Financial information provided by HTE differed how expenses were recorded between the SR and two RRH programs (Hope Mission, E4C). This makes accurate comparison among cost categories difficult; as such, averages were calculated overall.

Overall Costs

In examining the number of clients supported at any point in time in the program, a daily average was calculated among the sample. Using this figure against actuals, the total monthly spent in **RRH was $1,265/client supported** compared to **$230 for SR clients.** When broken down by client startup costs only, it is worth noting these are relatively equal.

While this would suggest that the RRH programs are more expensive than SR programs, given how different the nature of services offered and the target population is, it would be a misleading comparison. RRH programs offer financial and case management services and landlord supports, whereas SR programs are primarily a financial or furniture benefit with support services offered by participating agencies through existing budgets not accounted for the in the calculation.

Client Startup Costs

Looking closer at client startup costs that may be more comparable suggest that the CSU costs are about 50% lower for SR clients compared to RRH (**$1,228 vs $1,846).**

This might be related to the way CSU is being coded and eligibility for other financial supports from the program and will need to be explored further. A key limitation is that HTE was not able to provide ETO numbers for SR costs in the same manner they did for HM and E4C, which impacts comparability again.

CONCLUSIONS & HTE CONSIDERATIONS

In answering HTE's main questions driving the evaluation, a number of conclusions and considerations can be made from the analysis.

Are supported referrals effective in preventing chronic homelessness?

It seems that SR supports are effective in supporting a lower acuity population in accessing housing, thereby shortening housing instability. It is however unclear whether this cohort would have become chronically homeless longer term without the intervention. It is further unclear to what extent SR impacts housing stabilization and future recidivism rates longer term because of the relative short timespan of the implementation. This would need to be monitored longer term.

Are supported referrals a cost-effective housing intervention?

It would seem that SR supports are a low-cost intervention from an HTE standpoint; however, it would be inappropriate to use the HTE investment as a proxy for the full value of the intervention given that staffing supports are being delivered by the agency from other funding sources. In this sense, we did not have adequate data on the full financial cost of SR services for this analysis. Strategically, HTE has managed to shift focus in non-funded staffing resources in the sector towards its priority goals with minimal investment; however, the reliance on these staff will likely prompt non-profit management to ask for HTE to cover some of these costs if the program continues. HTE will likely need to develop a strategy to manage this issue if funding SR continues.

What is the experience of supported referral participants in accessing housing?

As previously mentioned, client participation was low in the evaluation with only four interviews volunteering to be interviewed. However, the general perception was very positive of the program, its staff, and flexible funding. Supports were reported to be person-centred and tailored, with varying housing choices being offered to clients.

What is the experience of participating agencies?

Service providers generally appreciated the availability of SR to support clients who did not qualify for other HF programming. They saw it as filling a key gap in the system of care. They, however, emphasised the efforts needed to support these clients were significant, and as such required them to balance new and additional SR work within their caseloads. Furthermore, there were some challenges reported with the integration of SR into agency workflow and some outstanding issues that require HTE clarification:

Clarifications

- Can clients reapply for SR post exit? If so, how?
- How much support or how little support is needed?
- Handling how to deal with tapping out of resources and managing prioritization.
- Explaining eligibility to clients.

BACKGROUND & OVERVIEW

Context

Homeward Trust Edmonton (HTE) is a community-based System Planning Organization that provides leadership and resources towards ending homelessness in Edmonton. HTE leads initiatives and programs, engages community stakeholders and partners, conducts research, creates awareness, and funds housing and support projects.

In July 2017, Homeward Trust launched the Supported Referral pilot project targeting individuals and families experiencing homelessness. Through this initiative, Homeward Trust makes financial resources and furnishings available to support service agencies to help their clients to access housing (e.g., by paying first month's rent).

The Supported Referral model represents an upstream approach that aims to prevent chronic homelessness that expands the network of partners that can achieve housing for people and supply supports to help them avoid a return to homelessness.

Evaluation Objectives

Homeward Trust engaged Turner Strategies as an independent external evaluator to conduct an analysis of the emerging data from the Supported Referrals project. The evaluation sought to assess the effectiveness and cost-efficiency of the project in achieving housing outcome. To assess impact against other models, the Supported Referrals stream was compared against Rapid Rehousing (RRH) and Housing First (HF) programming.

This report provides an overview of findings from quantitative and qualitative analyses. It will also be important to assess the experience of agencies and clients participating in the initiative in order to continue improving the Supported Referral approach – as such, interviews with SR providers (n=8) and clients (n=4) were also completed to build on these findings.

EVALUATION QUESTIONS

Question	Data Sources	Assessment
Are supported referrals effective in preventing chronic homelessness?	Supported referral data RRH comparison group	How many housings are being achieved? How many referrals are not resulting in housings? Are participants remaining housed for at least six months? How do housing outcomes compare for people identified at similar times with similarly identified acuity of need?
Are supported referrals a cost-effective housing intervention?	Financial data from SR and RRF cohorts Available data about use of FIND furniture bank	How do housing costs for supported referrals compare to costs for participants of similar acuity entering a Housing First RRH Program?
What is the experience of supported referral participants in accessing housing?	Semi-structured telephone interviews with SR participants (n=4)	To what extent do the resources available through supported referrals assist in overcoming barriers to housing? What is the experience of individuals in accessing furnishings through FIND? Do participants experience choice in their housing?
What is the experience of participating agencies?	Semi-structured telephone interviews with SR service providers (n=9)	What was their experience getting started with supported referrals? What can be learned or improved? To what extent has accessing supported referrals been “the difference” in getting clients into housing? To what extent do agencies value the supported referrals initiative and/or intend to continue with the project?

SUPPORTED REFERRALS PROGRAM MODEL

The Supported Referrals program was designed as an intervention to prevent chronic homelessness with a primary focus on single adults and families experiencing homelessness who have housing and support needs that can be addressed through limited financial and program support. SR is a short-term intervention designed to restore housing stability and to assist individuals in doing so as independently as possible.

Services Provided

SR program providers deliver the following:

1. Housing Support to engage potential participants, assisting client with finding housing, and setting up the client in housing.
2. Financial support for "client startup" funding to help clients access housing for use for items including, but not limited to, a security deposit, rent/rent arrears, utilities and utility hook ups including deposit, tenant's home insurance, startup groceries, and furniture and other basic move-in supplies.
3. Continued support services for a period of at least six months that already exist within the scope and capacity of the agency with an ongoing focus on greater community integration and the building of a strengthened network of support for the client.

Target Population

Supported Referrals are intended for individuals and families experiencing homelessness who require assistance in securing and maintaining housing, as well as connections to services and resources required to maintain tenancy. Compared to other programs, SR clients are experiencing homelessness for shorter durations, and have not yet reached one year of consecutive homelessness or multiple episodes over previous years.

The person or household will have identifiable barriers to securing and maintaining housing independently; the Supported Referral will provide the appropriate level of assistance to resolve the circumstance and move forward. It is designed to bridge the gap for households that would not require the level of service intensity offered in Housing First programs. It is also possible for chronically homeless households to be served through Supported Referral so long as there is a plan for appropriate intensity of support services according to the identified needs of the person.

Eligibility Criteria

Supported Referrals agencies must adhere to the following criteria when delivering the services under this program model:

- Identify clients who are **experiencing homelessness,** which means: they are without a permanent place of residence; living on the street, in shelters or in places that are not intended or suitable for permanent residence; are couchsurfing, or temporarily living with others for short periods of time.
- Administer a brief screening tool (Vulnerability Index-Service Prioritization Decision Assistance Tool, or VI-SPDAT) with clients who are potential supported referrals: clients will likely have a **VI-SPDAT acuity score between 4-9** (i.e. on the lower end of the housing assistance spectrum)**.**
- **Youth under age 18** are not eligible to receive this funding, except where the youth is supported by an organization that has received specific approval for supporting youth.

Funders

HTE is investing a total of $640,000 from April 2017 to January 2019 in this model through the Government of Canada's Homelessness Partnering Strategy's Innovative Solutions to Homelessness fund for $440,000 and the Government of Alberta, Community and Social Services for $200,000 through the Outreach Support Services Initiative.

Partner Agencies

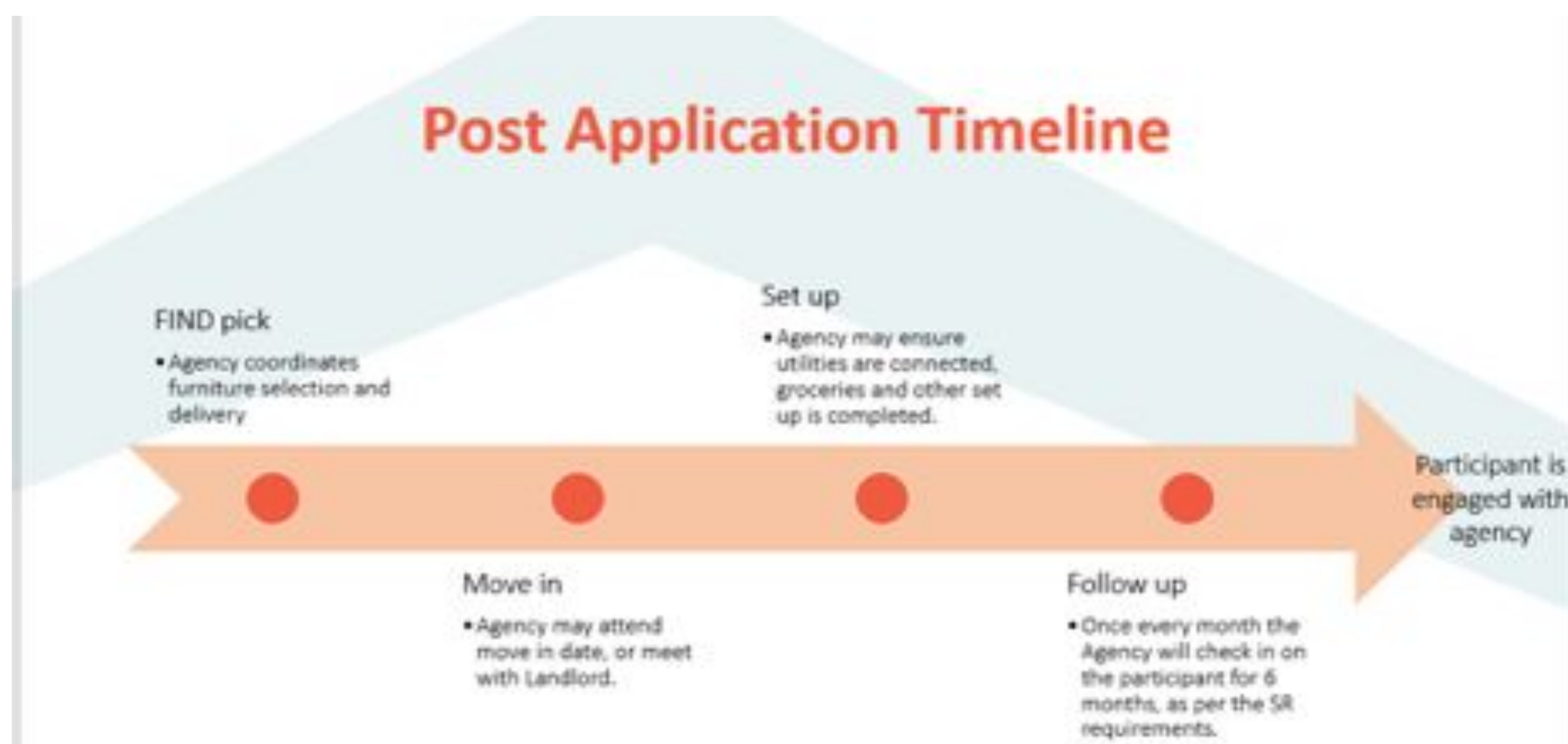
The following 10 agencies are currently (as of March 2018) contracted by HTE to deliver Supported Referrals services:

1. Bissell Centre
2. The Centre to End All Sexual Exploitation
3. Catholic Social Services
4. E4C
5. George Spady Society
6. Institute for the Advancement of Aboriginal Women
7. HIV Edmonton
8. Norwood Child and Family Services
9. Mustard Seed
10. Pregnancy Pathways

Process & Timelines

The SR process is initiated by the service provider when an individual shows they have a need for housing. The service provider then discusses a housing action plan with the individual which asks questions about what the individual is capable of on their own, what financial and supportive resources they have, and what ideal housing would look like. Once determined that the individual cannot acquire housing independently, the service provider completes a VI-SPDAT (with consent form). The service provider helps locate housing options and initiates the rental process.

Once a landlord has agreed to rent to an individual, a Supported Referral application is completed, which notes what client startup resources are being requested. At this point, the service provider forwards the relevant information to the HTE program coordinator for review. Any questions or clarifications are ironed out, and it is determined if the best course of action is to proceed through the Supported Referral project. It is at this final stage that the participant is accepted into Supported Referrals on ETO and is moved directly into Intake (hence a short time to Intake) and housing follows very soon afterwards (resulting in the short Intake to Housing time).



AGENCY & CLIENT INTERVIEWS

Phone interviews were conducted with eight service providers in Edmonton: Bissell Centre, Catholic Social Services, CEASE, E4C, George Spady Society, HIV Edmonton, Mustard Seed, and Pregnancy Pathways. Questions were asked regarding SR service model, target population, efforts towards long-term housing stability, and project implementation learnings.

Four interviews were also conducted with recipients of supported referrals to garner a lived experience perspective for this evaluation. Four short questions were asked related to how they became involved with the supported referrals program, what they received from the program, what they liked about it, and what could be improved.

What follows is a summary of common themes from these interviews.

Background

The eight agencies interviewed all have a particular role in the wider Edmonton homeless-serving sector. Some, such as the Mustard Seed, E4C, and Bissell are large agencies that serve anyone experiencing homelessness providing the typical range of services needed in responding to the complex issue of homelessness. Others provide specialized services to particular sub-populations. These include Pregnancy Pathways, Catholic Social Services (women in DV), George Spady (addictions), HIV Edmonton, and CEASE (sexual exploitation). In these cases, their main role is to provide specialized services and population-specific expertise and advocacy to the larger sector.

All agencies align with the Housing First approach. Some provide a full range of housing programs where housing first and supported referrals are available, depending on acuity and assessment. Other agencies that do not directly provide housing programs will refer to housing first programs using SPDAT.

Interviewees discussed what motivated their agency to take on the SR program. For many, SR filled a gap that was evident in the housing service spectrum. Interviewees explained that Housing First does not fit everyone, and there are often long waitlists. For these reasons, SR gives agencies a chance to help people that may not qualify for HF or would benefit from a short-term, timely intervention. In doing so, staff felt they are able to help more people:

> *We have people walking into our agency asking for help and are not able to access HF, or they can, but will have to wait. They only require start up funds to get them started; SR is good for these people…we are able to serve more people.*

Others were motivated to be able to provide a broader range of housing services to their clients, viewing SR as an important component of a more fulsome spectrum of housing services. In supporting people quickly, many felt that having SR as an option was a way of preventing future, more entrenched homelessness. Without SR, agencies reported they would see people fall through the cracks and end up in the shelter system – at which point, according to one respondent, they would then qualify for HF, adding more stress to an already-stressed system.

Another reason agencies were motivated to pilot SR was due to population-specific issues. In the case of domestic violence, it is well established that homelessness and risk of homelessness are strongly interrelated to domestic violence. One of the largest barriers for leaving DV situations is housing and finances. For the agency working with women escaping domestic violence (DV), SR was a way for them to access critical startup housing resources for women and their families. This is also the case for those exiting sexual exploitation.

Client Perspective

Of the four clients interviewed for this evaluation, three were women and one was male. Much like the agencies described above, respondents had a range of experiences that led them to the supported referrals program such as addiction, sexual exploitation, pregnancy, incarceration, HIV, poor physical health, unemployment, trauma histories, and domestic violence. They had diverse experiences with homelessness as well from living on the streets, couchsurfing, and living in unsafe/abusive/exploitive situations because they had no other alternatives.

All of the four came to their various agencies for related challenges, and through engagement with key staff people learned about the supported referrals program.

Basic Program Design

As described by those interviewed, SR is intended for those with low-acuity and ability to live and manage independently of supports (in contrast to HF). It is characterized as a "light touch" type of service where some support is given, but it is at the far end in terms of intensity.

In addition to the low-acuity and higher skill eligibility, each agency has its own target population for SR, largely determined by agency mandate. Beyond mandate, each organization typically has additional criteria used to help determine appropriateness with SR. The table on page 12 outlines each agency and target population followed by the typical population that access SR. It also identifies if the agency has criteria about homelessness, income, or other aspects.

As is apparent from the table, all but one organization – Pregnancy Pathways – target those with low acuity. Women who access Pregnancy Pathways are those who are pregnant and often have a host of other complex issues rendering them higher acuity than other programs intended for SR. Using SR for these women is a pilot project to see if this unique and time-sensitive population can benefit.

For the most part, agencies tend to accept those with short-term experiences of homelessness or about to become homeless through loss of housing. They appear to vary on whether the SR applicant must have sustainable income. For some, this is a requirement; for others, such as Mustard Seed and CEASE, this is not required and instead is part of the service support once someone accesses SR.

While the target population results from agency mandate, each agency has a typical population that tends to access and qualify for SR. Most are women and their children suggesting that SR is supporting those who are considered to be part of the hidden homelessness. One respondent explained that if a woman is caring for children, she tends to have significant skill in terms of independent living and only often needs the financial help to get housing set up. HIV Edmonton, in contrast, tends to see more Indigenous men through SR as well as Newcomers to Canada.

Prioritizing Access

Agencies have not yet had to face prioritizing certain people over others. Some explained this was because the program was still new while others stated they had enough resources to support everyone so far. Many stated, however, that they could see this growing as housing fills up and more and more clients come forward for SR. One interviewee stated:

> *If we start to get large volumes, then prioritization becomes really important; we won't want to provide funds for everything – we may have to make decisions/assessment about what the true needs are and can therefore serve more people.*

When faced with prioritization, interviewees had some ideas how they would decide. One stated that if children were involved or the person had significant health issues, they would give priority in these cases. Another respondent said they would handle it first come, first serve. Pregnancy Pathways stated that the due date of the woman would be one of the common ways they would prioritize clients.

In contrast to facing prioritization, another agency shared they are trying to make the money stretch, so they can help as many as possible.

Summary of SR Population

Agency	Target pop	Typical pop	Acuity Levels	Length of homelessness	Income required?	Other
Bissell	Anyone	Moms with families Alberta Works involvement	Low	Not chronic	Yes	
Catholic Social Services	Women in DV shelters	Women (age 20-35) with 1-3 children	Low	Living in DV transitional shelter	Yes	Living in DV shelter 6 months Attending programing
CEASE	Sexual exploitation; not active in addiction, not engaged in world of sex exploit	Women Addiction Trauma Health issues Indigenous Age 30-40 CFS involvement	Low-Mid	Unknown	No	Long term relationship with agency
E4C	Anyone	Women and families	Low	Must be homeless	Unknown	
George Spady	Addiction	Male and female	Low	Less than 6 months Short-term/new to homelessness	Yes	Able to live independently
HIV Edmonton	People living with HIV	Men Indigenous Newcomers	Low	No – breakdown in relationship, is losing housing	Yes	Stable but has housing issues
Mustard Seed	Anyone	Women, Sexually exploited Prior jail Mental health addiction	Low	Short-term homelessness	No – worker helps est this if doesn't have	
Pregnancy Pathways	Women, pregnant and homeless	Women, Trauma, Addictions, mental/physical health, trauma, Indigenous CFS involvement	High	Unknown – typically couch surfing	Unknown	Ability to live independently; motivated

Service Model

Referral Source

The majority of SR referrals come internally in the agency and from other programs. For those that receive SR clients externally, they tend to be from Alberta Works, inner-city agencies, Royal Alex Hospital, Corrections, Addiction and Mental Health services, and other community partners.

A few do not do outward promotion or encourage external referrals. These interviewees emphasized the importance of knowing the client to determine readiness and success for SR. Hence, referrals are preferable from other program components where a relationship has been established and the client's situation is well-understood. A staff person explains:

> *We've had some people come in for SR from other agencies, but they don't access our programs…worry is SR won't be successful because this person doesn't access us, doesn't have the relationships with us, and we lose contact and are unable to provide ongoing supports.*

Intake/Assessment Processes

A blend of informal and formal intake and assessments tend to occur across agencies through conversation, relationship building, SPDAT, and information gathering. In some cases, staff will engage in conversation with a client (in a drop-in space for example), learn about their situation, and through this may determine that this person would fit with SR. A SPDAT assessment would then be used to determine acuity.

Other organizations follow this similar process in that there is a lot of talking to the person and understanding their situation with the aim of determining stability and skill level: "we engage with them and can quickly determine if they would fit for SR." This is also where the theme of relationship re-emerges. If the person is known for a long time in other programming, it is much easier to determine if they will be appropriate for SR: "Relationship is key…if we just take a referral from another agency and don't have a conversation with the person, we find they are not really successful – we like to get to know the person to understand them better." For another organization, this involved gathering extensive information such as debt history, tax filing, eviction history, challenges, and housing experiences, ultimately looking for some evidence that the person will be able to maintain housing for six months through income or skill.

A somewhat different approach is used with women in domestic violence shelters. When a woman first moves into the shelter, staff conduct a SPDAT to see where she is at in terms of acuity. In doing so, they are engaging in early identification of potential SR clients. These women are then reassessed at the six-month period to see if SR is still appropriate. All agencies use SPDAT to assess acuity.

Services

Once a person has been determined to be appropriate for SR, staff fill out the application that goes to Homeward Trust for final approval. From here, how service delivery unfolds generally occurs across three phases: set up, contact/follow up, and exit/long-term support.

Set Up

As explained by interview respondents, SR enables qualified people to access funds for housing set up such as a damage deposit, rent, utility startup, furniture, food startup, household startup costs, and tenant insurance for one year.

Some agencies require the person to set up their own housing – they need to find the housing and make necessary arrangements with the landlord. Clients then need to provide a rent report or lease agreement as evidence. Once this had been completed, SR will step in to support them financially in the areas mentioned above. One respondent stated, "we can give a lot of money with SR – but we try to negotiate to see what the client can contribute – to work through the details to determine what the biggest needs are."

In other agencies, staff does more hands-on work helping the client get set up. This can involve help with finding housing, visiting housing, writing applications, working with the landlord, setting up social assistance, finding schools for children, and getting startup groceries and furniture.

Contact/follow up (six months)

Even though SR is defined as a "light touch" type of intervention, many organizations are providing a lot of support. One respondent explained that people in SR, "are not receiving follow up support like they would in other RHH where a staff person is going into the home once a month and following up in a direct way." Instead it appears that the majority of agencies are providing varying degrees of follow up with SR recipients for six months following housing setup. The frequency and intensity of the contact seems to occur on a continuum with one agency strictly conducting a monthly follow-up phone call to see how things are going, and to connect the person to any other needed supports in the community.

In the middle of the continuum, the frequency of contact increases to possibly weekly and/or active outreach where staff attend home visits or meet the client in the community regularly. Contact for three organizations is largely participant-driven, meaning that staff will make themselves available if the client should need or want to connect beyond the monthly contact. For some programs, such as CEASE, this contact can be intensive, depending on circumstance. Similar intensive supports for Newcomers are often required from HIV Edmonton staff. In cases like this, "The worker does follow up support at home and in community as needed; ensures people have a support plan, and are accessing supports, having ongoing conversations about housing, and are looking for red flags." Here respondents talked about the importance of building relationship and ongoing engagement with organizational programs helping staff maintain a sense of how the person is doing in housing.

At the far end of the continuum are more intensive supports such as that provided by Pregnancy Pathways where women have apartments in an agency-run building. As such, they have access to staff 24/7.

Independent of frequency or intensity of contact, all organizations work to connect SR recipients to any needed internal or external services. Many spoke of the importance of connecting people to their community and fostering social relationships. Clients are supported in accessing any identified need such as life skills, employment supports, parenting supports, social clubs, collective kitchens, counselling, and more. In addition, many of these organizations have partnerships or relationships with various systems such as health, criminal justice, and child and family services. As such, if an SR client needs to navigate a system, similar supports would be provided as would be for any client accessing the agency.

As far as ensuring services are culturally-sensitive for communities such as Newcomers, Indigenous people and LGBTQ+, agencies have continued their standard practices for those involved in SR. No specific SR strategies have been implemented. Instead, practices already in place such as Aboriginal Awareness training, partnerships with the local pride centre, and immigrant serving agencies, are part of the agency culture of inclusion and as such are expected to continue for SR recipients as needed. This was consistent for all agencies interviewed.

Exit & Long-Term Supports

Formally, SR is meant to end at the six-month period with the aim of the person still stably housed. For one agency, this is where contact formally ends, but the person is invited to access the agency for any future needs. Other organizations, similar to the provision of contact and follow up, do not have a six-month firm cut off. If support is still needed, several respondents stated this would be provided even though the person is no longer officially enrolled in SR after six months.

Overall, agencies are going above and beyond current contract expectations for SR to provide supports; they believe is necessary to ensure the person remains housed.

Pregnancy Pathways has a different exit process set up because of its population and resource limitations. Once the baby is born, women need to leave the housing unit to make space for the next pregnant woman. This usually occurs six-to-nine months post-baby. The aim is to move women to other affordable housing and put supports in place, but there is currently limited affordable housing available and little in way of financial supports.

In terms of establishing long-term stability, much of the contact during the official six months through SR is to help set up connection with community resources. As discussed above, some agencies will provide what is needed to support that person long after the six months has expired and are clear that their door is always open for someone to return. For one however, no long-term supports are available due to resource limitations and agency mandate.

Success is formally measured by how many months the SR recipient is able to maintain housing – with the goal of six months. Monthly contact and whether the person is housed are recorded. Outside of this, agencies largely look to anecdotal experiences that are captured through ongoing relationships. When relationships are strong, staff hear how clients are doing and have a sense of if they are stable, safe, and happy. Some respondents described that when they see an increase in confidence, they also see the ability to deal with health issues, employment, hope, and/or social connection as examples of qualitative indicators of success. Others are whether a housed mother is able to keep her children with her. The following quotes illustrate further indicators:

> *If they can maintain contact, if they are able to maintain contact in the community, keeping their children with them.*

> *By the number of women housed and that they are stable and safe and are reporting to us that they are happier.*

> *We know it's a success when someone graduates at six months, we see increase in confidence, they are able to deal with their health issues, not in jail, working, looking towards the future, skill levels growing too.*

For those who are not successful with SR, the majority of organizations stated they would be allowed to return for services, and possibly reapply to SR. Most stated it would depend on the individual circumstance and would need to understand what did not work in the prior situation. For example, if more supports were needed, then perhaps the person would be better suited in a housing-first type program. Interviewees were clear about not wanting to set the person up for failure in SR if it is not a fit.

One respondent was unsure if a person who was unsuccessful with SR would be allowed to re-apply and another firmly stated that no, this was not permitted by the funder but that the person would be welcome to access other housing supports. There was some concern about becoming dependent on SR if allowed to reuse it suggesting there is some discrepancy in understanding whether SR can be reused.

Outside of reapplying to SR, agencies stated that they would work to find other housing options for the client. This included a shelter referral, or other housing options such as Rapid Re-Housing or Intensive Case Management. Pregnancy Pathways currently does not have a way of helping a pregnant woman who is evicted other than through standard community programs available for all homelessness.

Client Experience

Once clients had learned about the supported referrals program, they described a brief assessment and approval process. Once approved for supported referrals, respondents described how they found housing. In some cases, their agency helped them find housing, or had access to housing, and in other cases they were expected to find housing on their own. After providing a lease agreement, people were connected with several key supports such as a damage deposit, first month rent, access and payment for furniture, and startup money for household items and groceries.

All four respondents emphasized the emotional support they received in addition to the financial aid through the participating agency. In all cases, the staff person conducted weekly phone calls for a check-in and/or face-to-face meetings every few weeks to once per month. During these exchanges, staff are asking how the person is doing, connecting them with resources, inviting them to other programs and social events, helping with paperwork and accessing government benefits, and providing important emotional support. All respondents described this as an important relationship where they felt supported.

Program Implementation Learnings, Challenges and Possible Changes

In this section, interviewees reflected on the implementation process, ongoing learnings and challenges and suggestions for change. The four clients were also asked about what could be changed or improved. What follows are themes from this part of the discussion.

Referrals

Several of the agencies interviewed discussed their learnings about appropriate SR referrals. Some described how they have had people receive SR, and then have come to be unsuccessful in maintaining housing. Upon reflection, it was determined that staff, at times, can be driven by the desire to want to help someone, and may end up making an inappropriate referral: "We don't want to provide more than what someone needs. We need to determine what is helpful; workers sometimes want to give everything. We are mindful of learned helplessness…and need to teach workers how to have those conversations." As such, they "are a little bit more cautious about who is most suitable for SR – if they need more support then what we are able to give."

Another important learning about referrals, according to respondents, is ensuring they have enough background on someone. This speaks to conducting a thorough assessment or, in the case of someone unknown to the agency, "waiting to see if they are willing to the do the work and follow through."

Two discussed being more cautious about referrals based on available staff resources, which are quite limited (see separate discussion on resources).

Integration of SR within Agency

Another theme related to the topic of implementation and key learnings is one that involves integrating SR into the agency. Respondents spoke about it being a "trial and error" process and one that involves "ironing out the details" and "working out the kinks." Integration activities include having clarity and knowledge about how SR operates, figuring out the best way it can be done, data entry processes, balancing staff loads, and how different programs will interact and impact each other. For several, SR is embedded in other programs, resulting in a need to build structure and process.

An interesting comment was shared related to communication about SR across client groups. Part of this agency's learning has been how to talk about SR when some of the clients are able to get it and others are not. This is more present in service models that have a close community where clients find out what others are receiving for supports.

Overall respondents saw this as an expected learning curve – one that occurs when any new initiative is implemented. Over time, structures and processes have evolved making this less onerous. One agency is currently working on creating a system that will allow for better assessment of needs and supports and how to make SR more sustainable and able to support a greater number of clients.

Resources

Resource constraints have been a dominant theme from the interviews. As mentioned above in the referral section, some agencies find they are making referral decisions based on current staff resources. SR is added to current workload for one person or spread across several. One respondent stated they are finding SR "resource heavy" while another stated, "we are already maxed out for time. SR is already above and beyond the staff's role."

One respondent indicated, "It would be helpful having a person dedicated to the SR follow up – this would allow us to support more people and follow up in-home. Right now it's on an as-needed basis." Others made similar statements about the need for a dedicated person and how this would contribute to the success of the program and its potential growth.

Current Challenges & Possible Changes

Current challenges faced:

1. SR cheques are sent directly to the landlord from the participating agency. In the case of those living with HIV, this results in a risk of disclosing status to the landlord as the agency cheque has HIV Edmonton on it.

   Possible change: Issuing cheques directly to the client or having HT issue cheques.

2. Currently, SR money is not available to pay off rent arrears. There is a big need for this and could act as a bridge.

   Possible change: SR money become available for rent arrears to avoid eviction.

3. In the case where someone is getting evicted and where the landlord does not want them there, they have to wait until they become homeless to qualify for SR.

   Possible change: Allow for some leeway in these cases to avoid homelessness.

4. Immigrants who do not have immigration status or refugee claimants are not eligible for SR. Two agencies see a number of people in this situation.

   Possible change: Extend SR to those without status.

5. There are some people who measure too high in acuity for SR but too low for HF, who then fall through the cracks.

   Possible change: Allowing for higher acuity but longer term support such as over nine months.

6. If a person does not have enough income to maintain their housing then staff have to go through an onerous process to help establish government income supports. This takes up a lot of staff resources.

   Possible change: The SR worker being able to directly ask for money from Alberta works ($300).

Comments from a Client Perspective

It is important to first note that the four clients interviewed had incredibly positive things to say about supported referrals. Generally speaking, they had trouble in thinking about what could be improved. A few suggestions were made, however.

1. **Longer term financial support.** One respondent offered the idea that financial support for rent could be extended over a few months with gradual reduction to help ease the transition to independence while simultaneously increasing income support access.

2. **Increase awareness**. Another respondent felt the program should be made more widely available, explaining she only found out about it because she was connected with a particular agency. She felt there are many people who could benefit.

3. **Increased Access/Support for those with physical disabilities**. A final respondent with significant health challenges indicated that it was difficult at times to find housing. Using public transportation and going from location to location was difficult for this respondent due to his physical health. He voiced concern for those who may be in a wheelchair or have other physical disabilities, and suggested that direct support be provided in these cases. For example, having a staff person drive a client would improve access.

Successes

When asked about key moments that illustrate success, a few spoke about how SR has enabled them as an organization to be more responsive to their clients:

Prior to SR, we'd have to refer out to other agencies through Homeward Trust such as intensive case management – once our clients graduated from these programs, they crashed because there was no ongoing support, returned to the sex trade to make ends meet.

SR has made things more efficient – we use to have to go to three to four places to find money; now we go to one stop. SR helps us mitigate a crisis, and then we can deal with other issues.

Service provider respondents also shared some success stories about clients:

One woman didn't have a home for 22 years; she had complex health needs. She is now housed for eight months and has been able to get on top of some serious complex health needs and reconnect with family.

A woman was going to lose her housing because her partner died, and she couldn't afford the housing. SR helped her get a security deposit, groceries, the whole continuum…We love the program; it's a game changer in how we've been able to support people!

A woman was in jail for six years, then went into a halfway house. She utilized SR and our employment program. She is now housed, employed, has reconnected with family, and is hopeful.

There are five healthy babies in housing – two living with mom, others have arrangements with child services. Without SR, this may have resulted in a very different circumstance…if a woman is homeless and pregnant, apprehension is a given. Having a home gives children's services a place to work with the mother.

An older woman, with a high level of education, left an abusive husband. She struggled to find work and income. SR allowed her to get her own place, furniture, money, and a sense of self she's never had.

Client Experiences

The four interviewees easily shared how receiving supported referrals has impacted their lives. Several indicated they did not think they would be able to have stabilized in housing without the program, in particular, getting together enough money for damage deposit and rent was insurmountable:

I couldn't get enough money together for a damage deposit – could only afford half on my own.

I think it's good to help people in need, for me being pregnant and being in the industry [sex trade]…I wanted a life change but because of my job it was hard because of my income – I was on income support – saving for a damage deposit would have been impossible. The first month really helped because I was able to use the extra money to get stuff for baby.

SR got me my own place – got me set up – a real leg up. I can maintain it, that's not a problem, but getting situated in it on my own, I couldn't do it. Everywhere else I couldn't get set up – I'm an honourable renter. I'm the right kind of person for it – because I am clean – I can keep maintaining it.

I wanted a home so bad, I would go to social services they would say, well you need a home, but if I don't have social services, no one will rent to you – it's a vicious circle.

The combination of financial and emotional support/relationships with staff was key:

I don't know if I would have been successful without SR…Without the emotional support I could have relapsed – you need the emotional support, the home stability – the chances of falling back into addiction are high without it.

I don't trust people, I do trust her [agency staff member] – she's the one person I trust. The connection has been really important – I don't know where I'd be right now. I'm a well-behaved guy that has been mistreated.

Overall impact was significant for respondents:

It saved my life, I'm an ex-addict…they gave me rent and a damage deposit. It got me out of the neighbourhood where I use to work [sex trade] and use in – it gave me a new start – not only just being clean, but clean in a new home.

This made a huge different for me – I would have been without a steady place. My baby is born now, and we are settled in my place.

It was a blessing – I love everything – it offers opportunities to people that they didn't have…My life would have been different without it. The housing has helped me stabilize – anxiety, depression…and given me a good start.

I liked everything [about SR] – I was awestruck – I wasn't aware of anything like that – I had no idea this was available.

SUPPORTED REFERRALS DATA ANALYSIS

Quantitative Variables

The average age in the sample was 41 years old, with 30 months homeless, and 2.4 episodes in the past year.

The VI-SPDAT score was about 7 and average numbers of days in the SR program was 113 – almost four months.

The average number of dependents was 0.8 per participant.

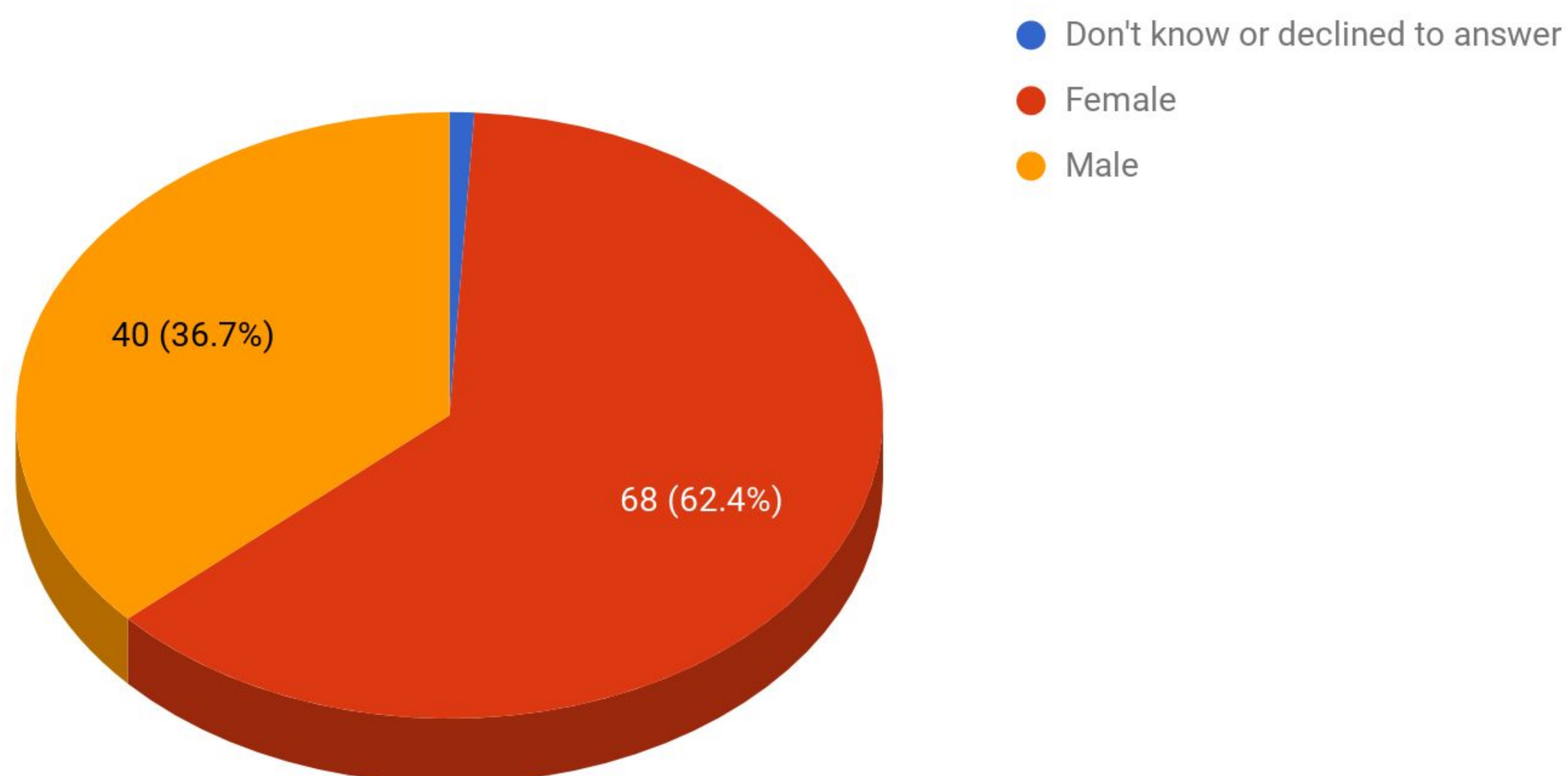
The remainder of the histograms in this section highlight the distribution of the data across these quantiative variables.

	Age	Months homeless	Episodes last year	Acuity (VI-SPDAT score)	Dependants	Days in Program
N	109	107	104	108	102	84
Mean	41.1	30.1	2.38	6.92	0.814	112.8
Min	19	0	0	1	0	8
Q1	32	3	1	5	0	61
Median	19.0	12.0	1.0	6.5	0.0	111.0
Q3	49	32	3	8	1	157
Max	75	336	12	14	5	257
Standard deviation	12.1	57.4	2.95	2.46	1.17	63.6
Coefficient of variation	30%	191%	124%	36%	143%	56%
Skewness	0.46	3.91	2.16	0.62	1.55	0.39

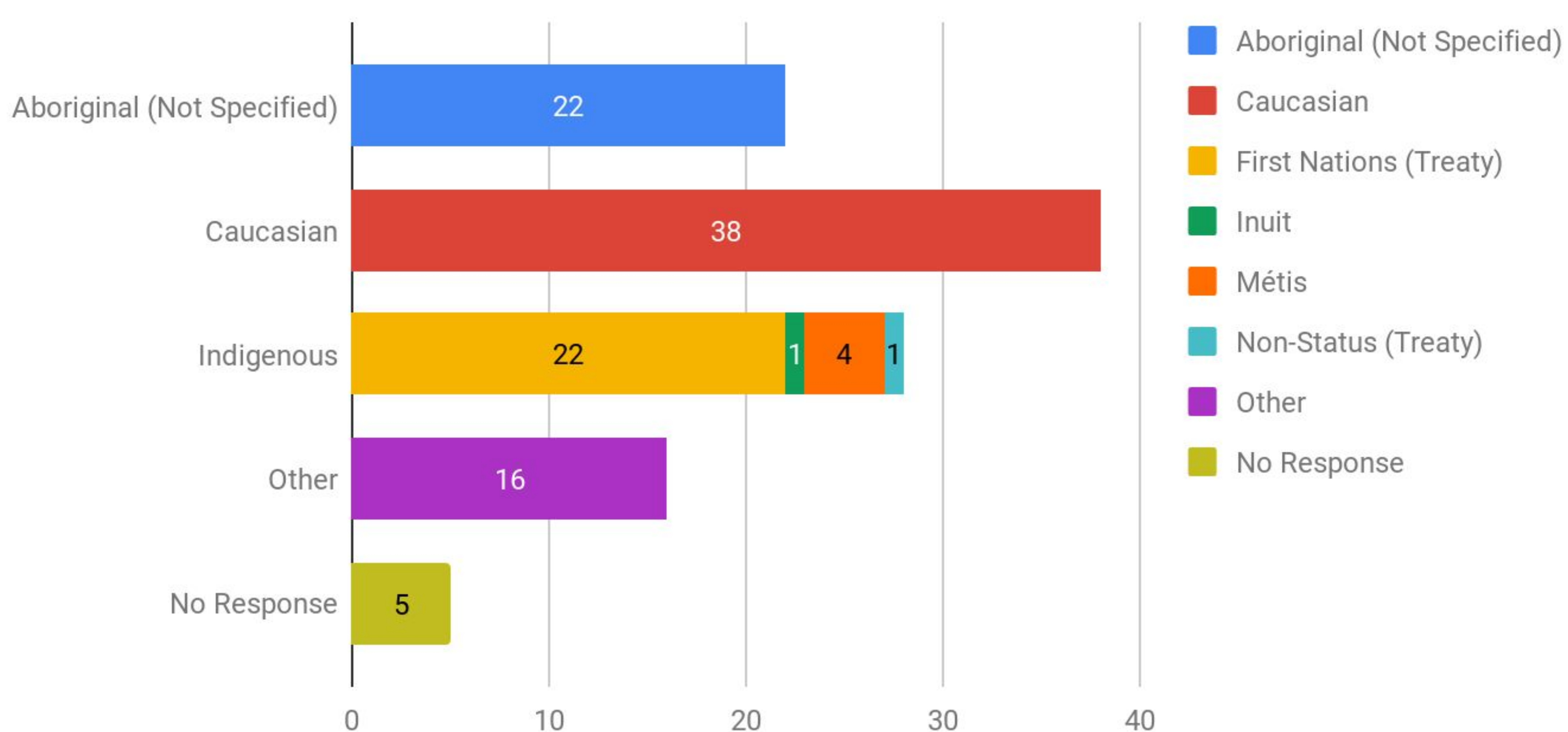
Significant Relations in Supported Referrals Sample (n=109)

Significant relations among variables are summarised below for the data set. Note, the smaller the p-value (below 5%), the more significant the relation is among the variables.

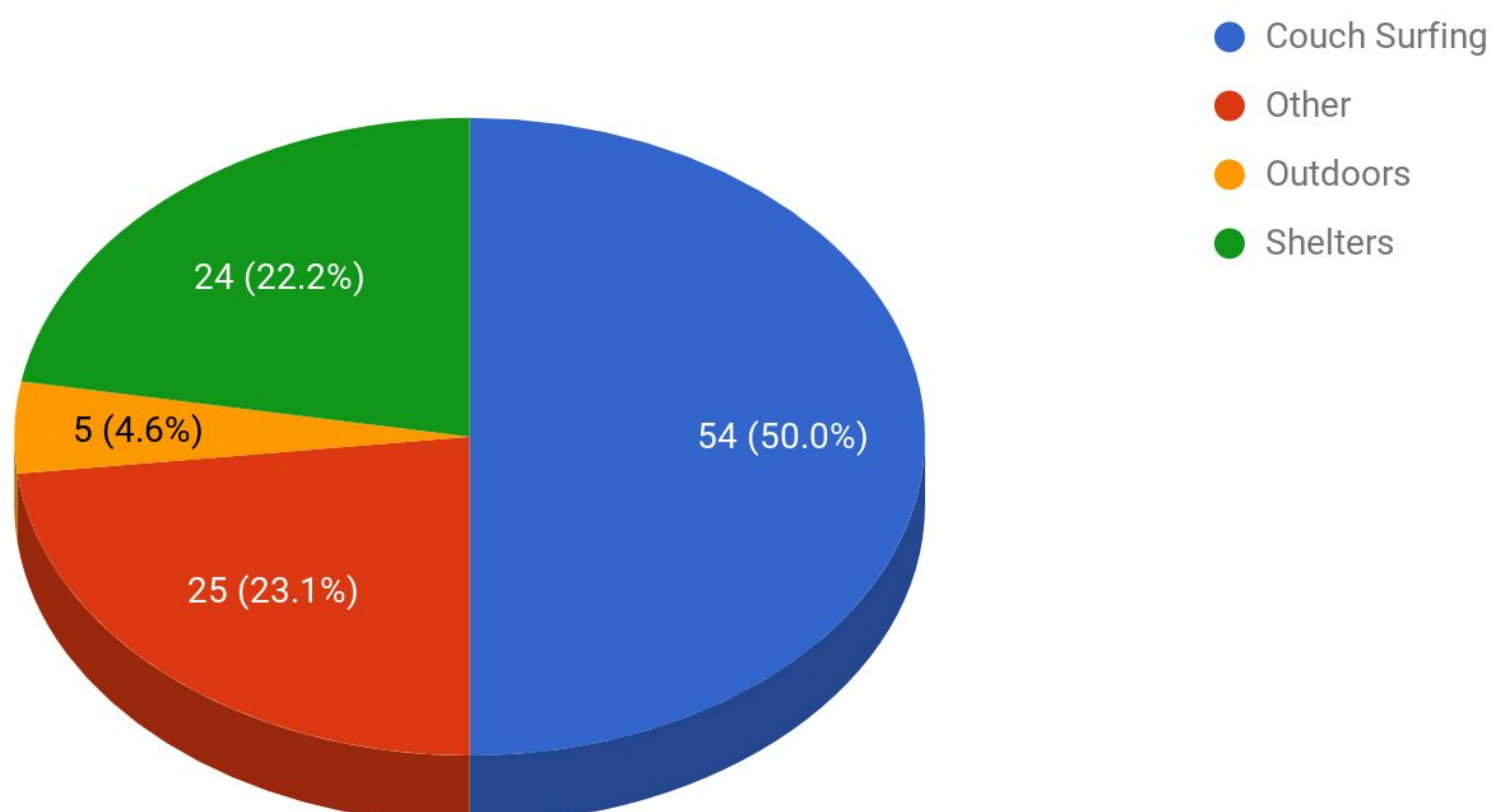
Variable 1	Variable 2	p-value	notes
Age	Acuity (VI-SPDAT score)	0.02362	P-value is high, but may suggest older clients have higher acuity scores.
Age	Dependants	0.00024	P-value is high, but may suggest younger clients are likelier to have dependents.
Months homeless	Acuity (VI-SPDAT score)	0.01060	P-value is high, but may suggest the more months homeless, the higher-the-average acuity score.
Months homeless	dependants	0.00568	P-value is high, but may suggest clients with dependents are likelier to be homeless for lower number of months.
Gender	Age	0.04990	Men are older than women in the sample.
Gender	Dependants	0.01014	Women are likelier to have dependents.
Gender	Ethnicity	0.00212	The proportion of men is higher for the Caucasian group compared to other groups.
Gender	Organization	0.00181	The Bissell Centre had more men, whereas CEASE, CSS, E4C and IAAW had more women.
Ethnicity	Episodes last year	0.00022	Métis had a significantly higher average number of homeless episodes, but there were only 4 Métis in sample. There were no differences in groups with larger samples.
Ethnicity	Organization	0.00014	Small p-value can be accidental caused by single observations. More data necessary to cinficonfirm.
Location at assessment	Organization	0.00998	CSS clients had assessments only in shelters, while CEASE only couchsurfing.
Organization	Age	0.04119	Pregnancy Pathways had younger clients (only 2 records though); HIV Edmonton had older clients.
Organization	Episodes last year	0.00056	Difference betwin HIV Edmonton and IAAW in number of episodes reported.
Organization	Acuity (VI-SPDAT score)	0.04733	Averages in acuity score differ among organizations.
Organization	Accessed FIND (1, yes; 0, no)	0.03133	All IAAW and CSS clients had dependents.
Accessed FIND (1, yes; 0, no)	Prioritized for Supported Referral	0.02202	Those who did not get prioritized for SR were likelier to not get access to FIND.



The majority of program participants in SR were females (62%) compared to males (37%).



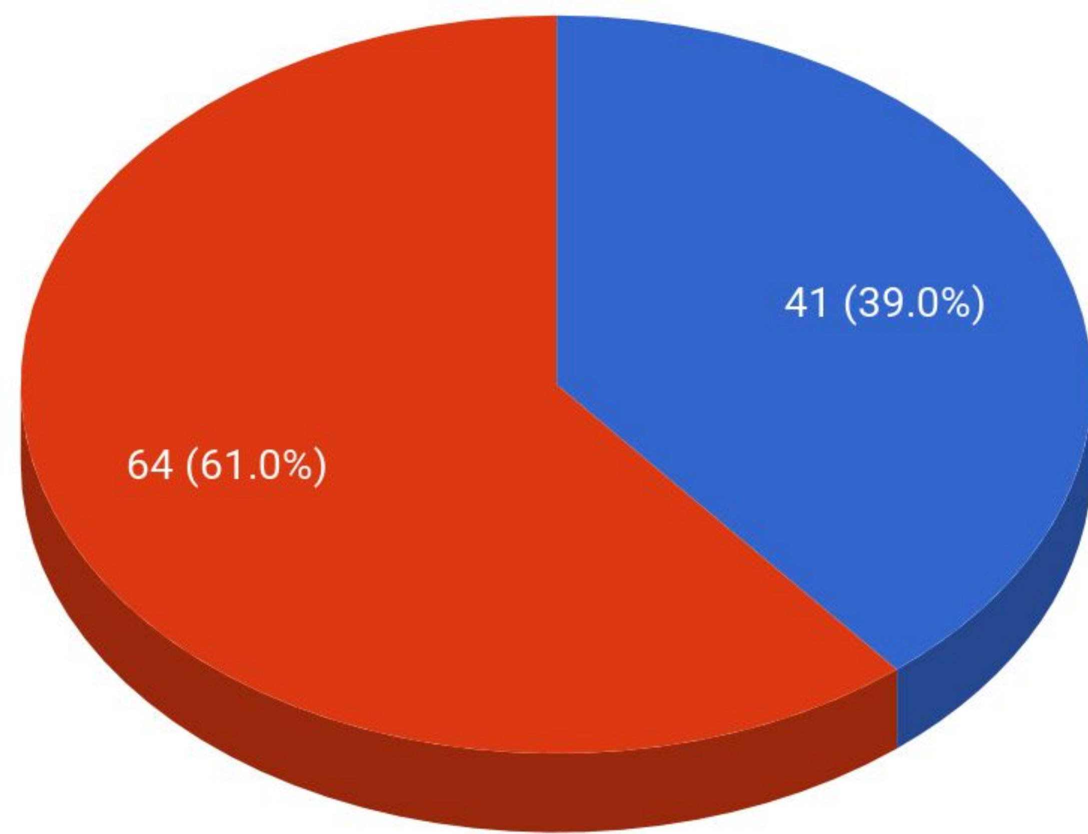
The self-reported ethnicity of most clients was 35% Caucasian, 20% First Nations (Treaty), 20% Aboriginal, and 15% Other (presumably immigrants or visible minorities). The balance were Métis, Non-Status Treaty, Inuit, and No Responses.



The majority of program participants in SR came from couchsurfing (50%), followed by shelters (22%) and other locations (23%). Only 5% came from outdoors.

Accessed FIND. N = 105

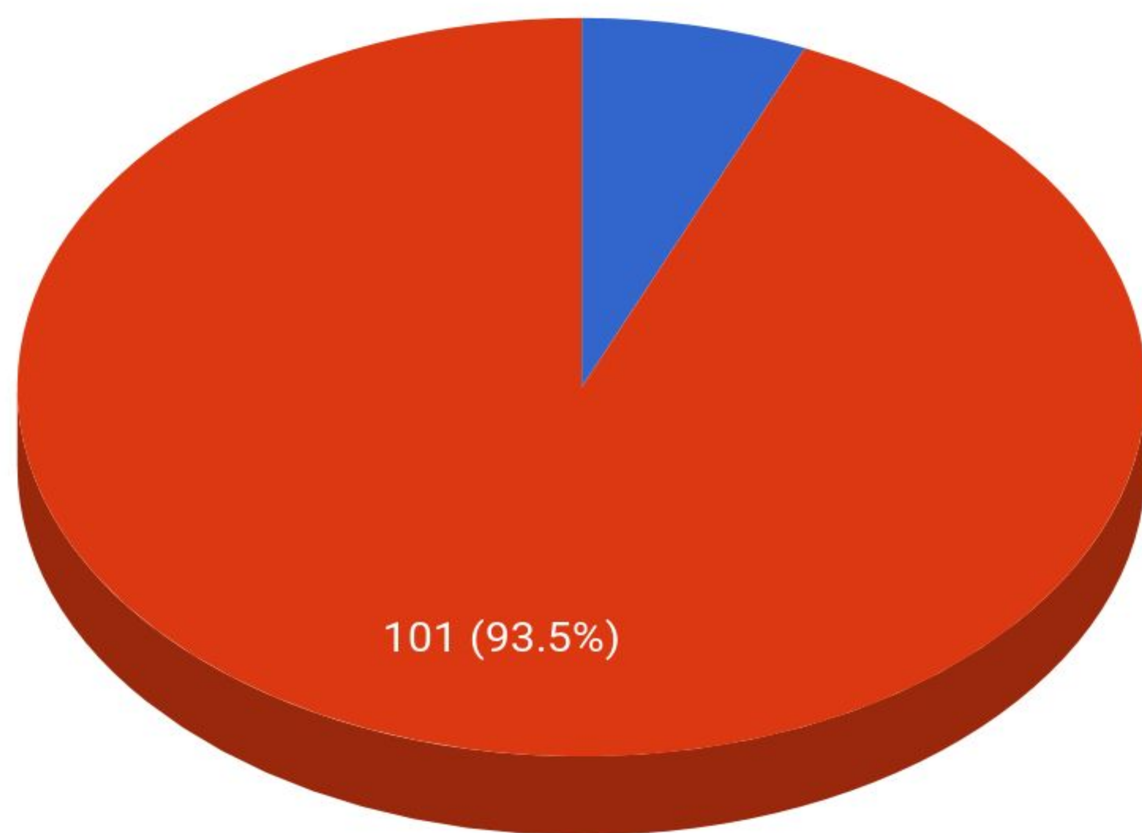
No
Yes



About 61% of SR clients access the FIND furniture store; the balance did not.

Prioritized for Supported Referral. N = 108

No
Yes

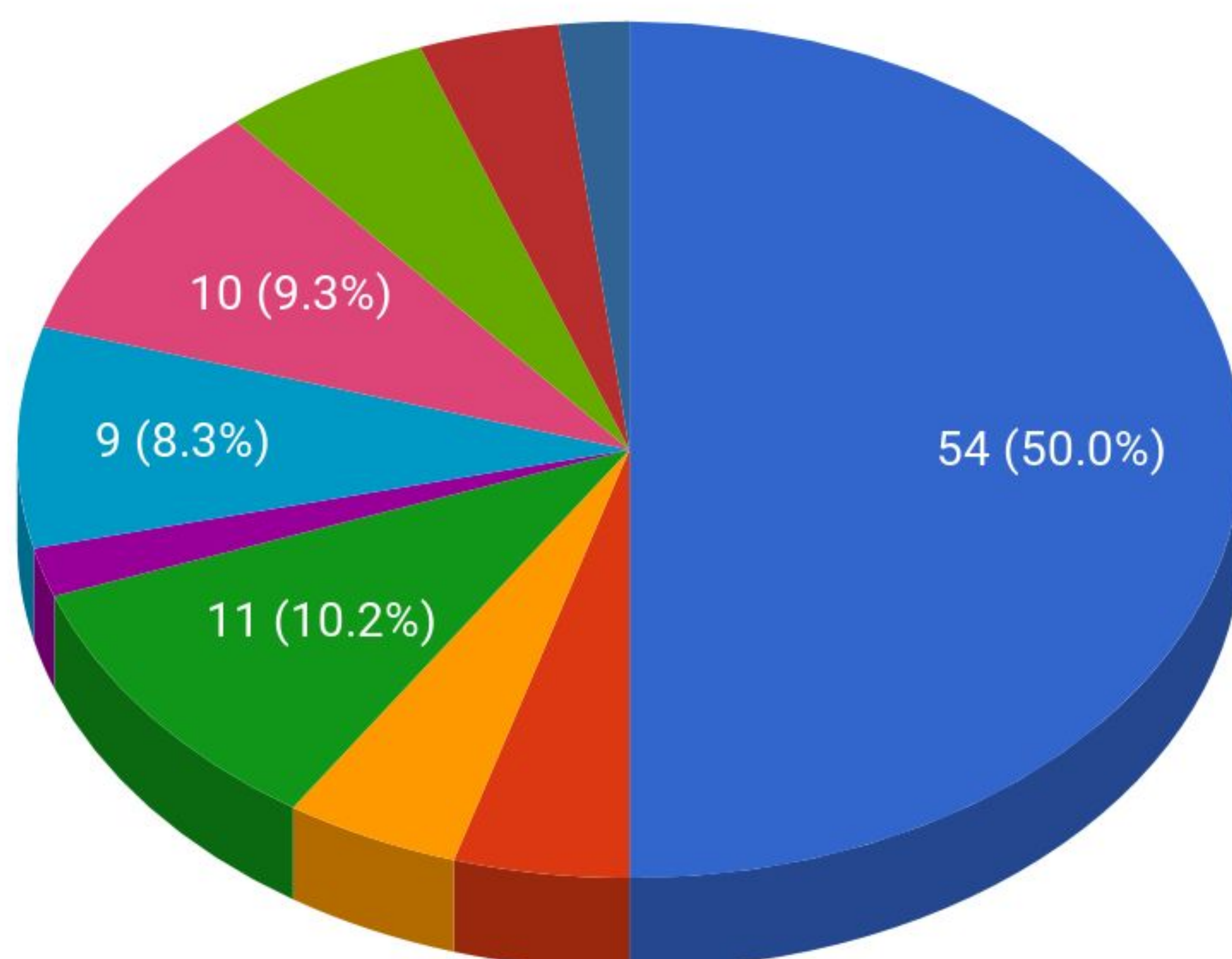


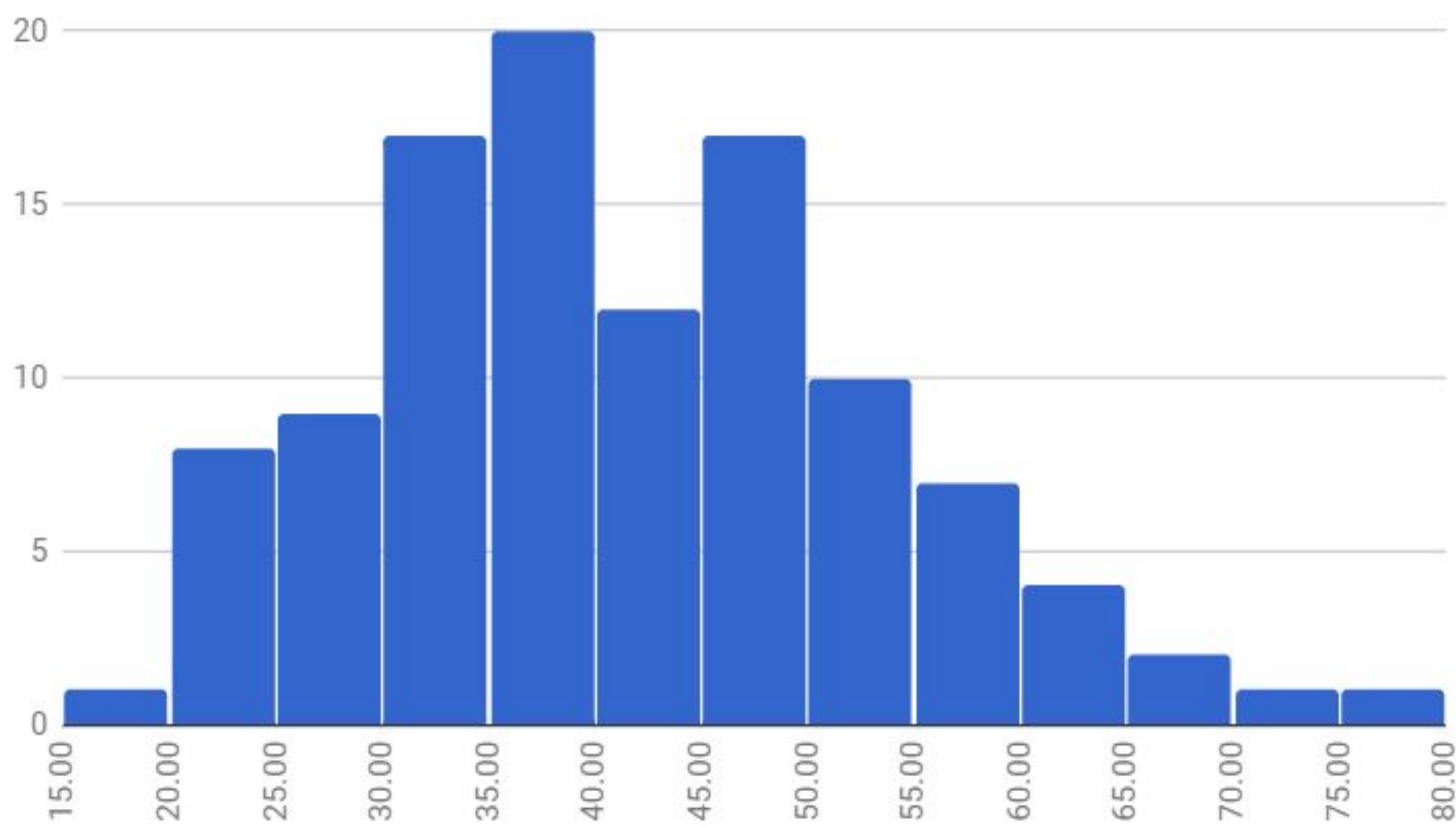
Most (94%) were prioritized for SR referral, which aligns with the eligibility criteria prescribed in agency contracts by HTE. This might suggest that agencies used VI-SPDAT scores appropriately such that only a few SR referrals have been re-prioritized for ICM.

Bissell Centre accounted for 50% of the SR clients in the sample; the balance was distributed relatively evenly among the other nine service providers.

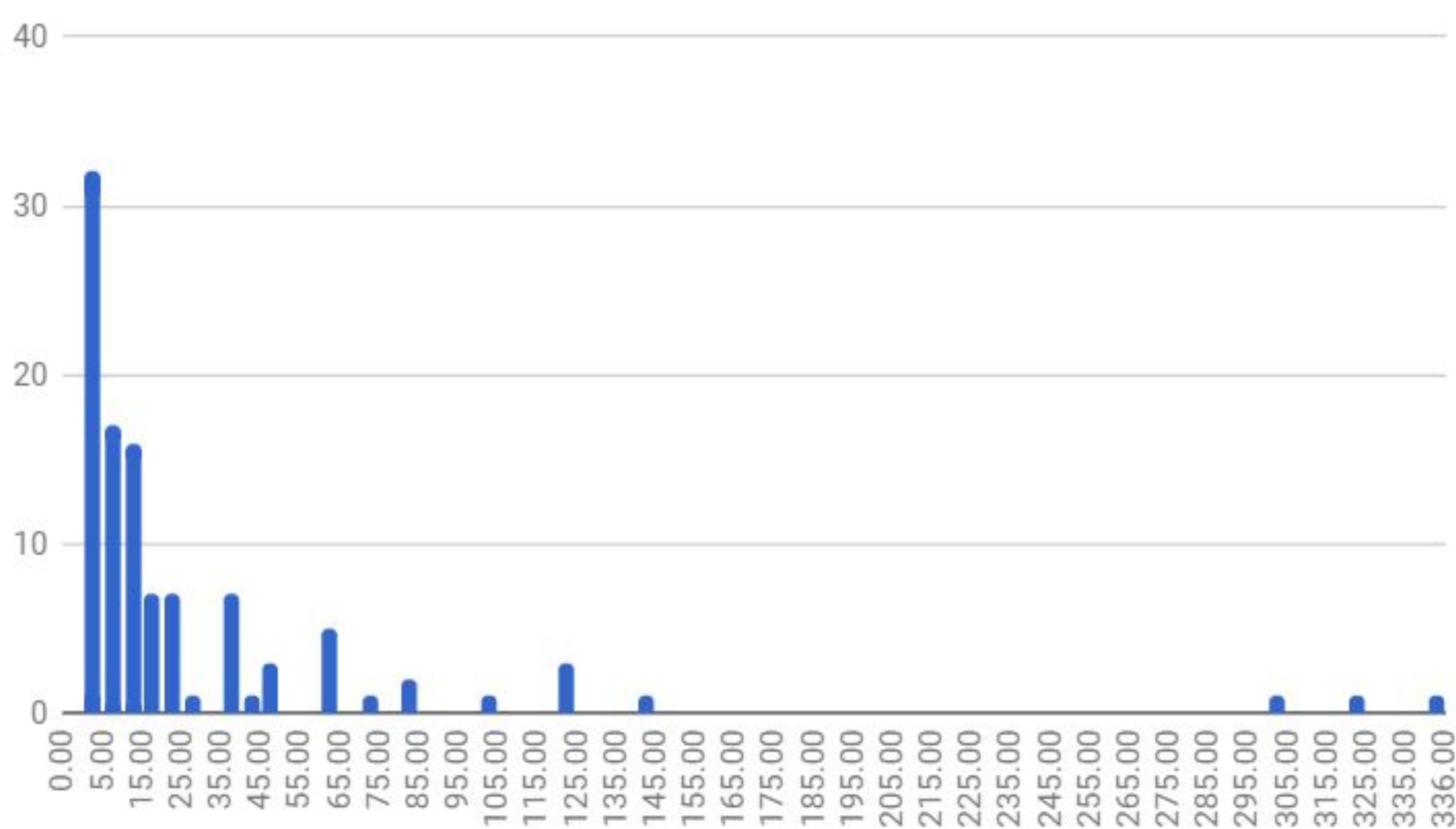
Organization. N = 108

Bissell
CEASE
CSS
e4c
George Spady
HIV Edmonton
IAAW
Mustard Seed
Norwood
Pregnancy Pathways

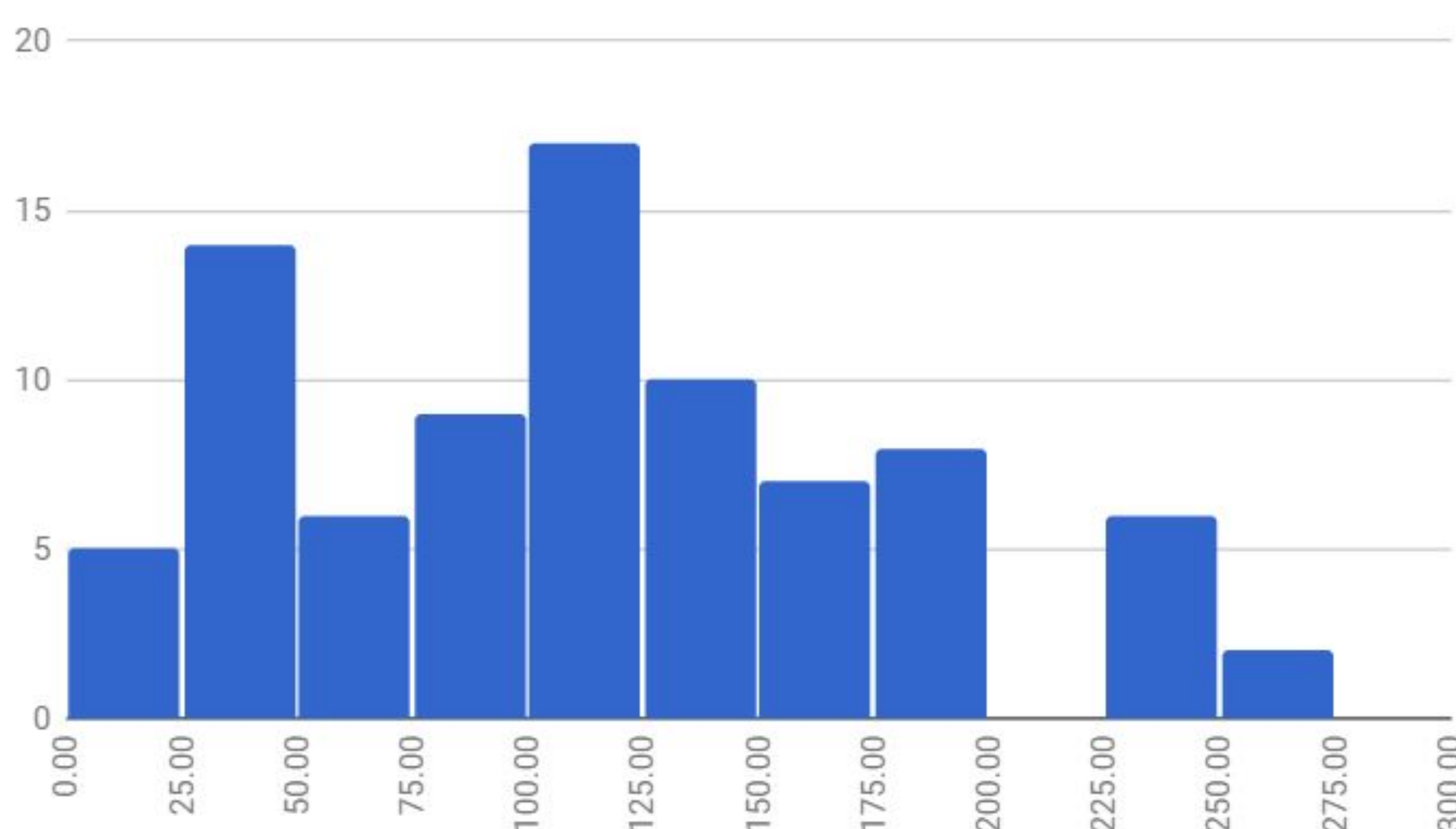




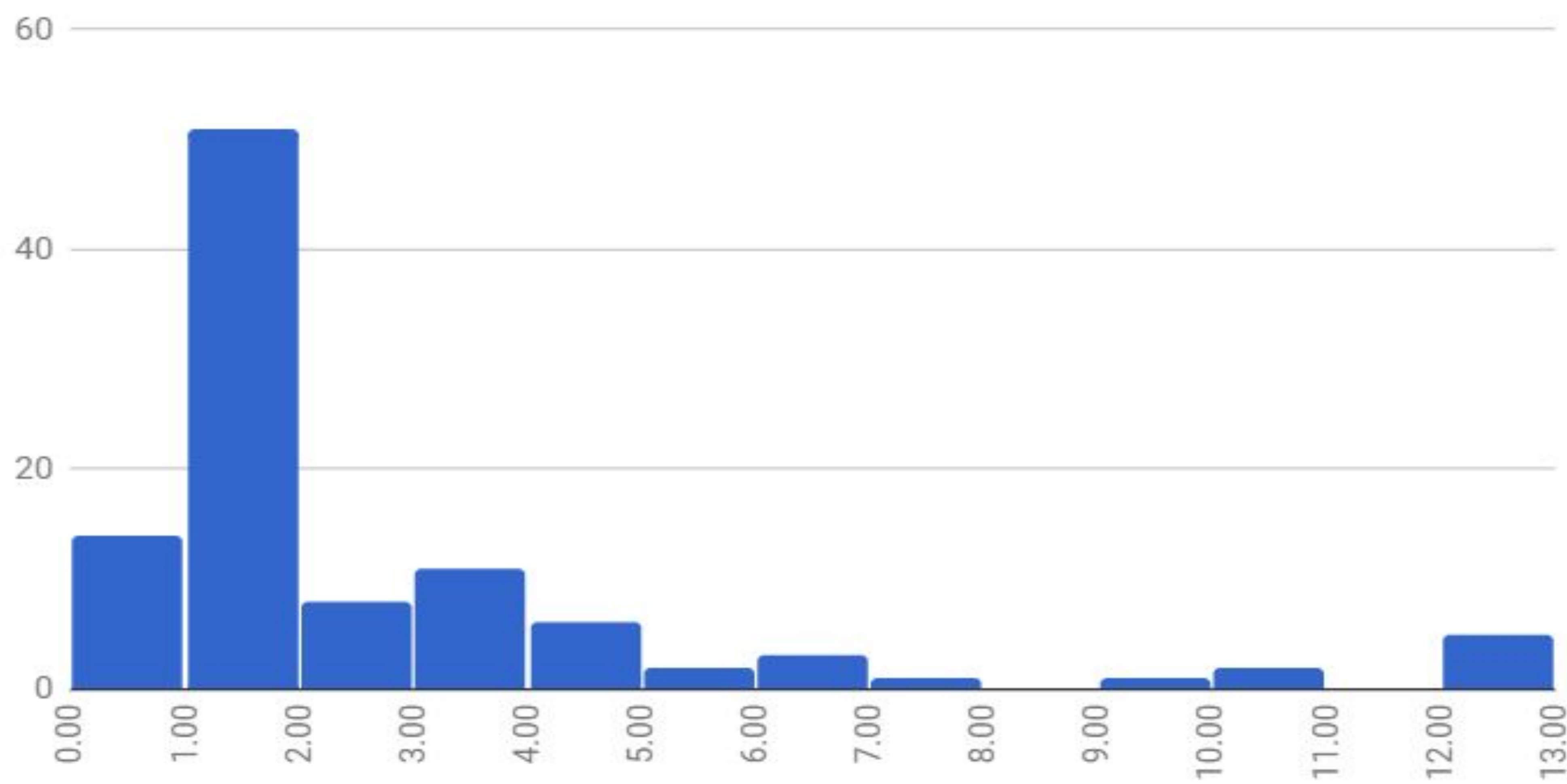
Most clients were working age, from 20-55 years old.



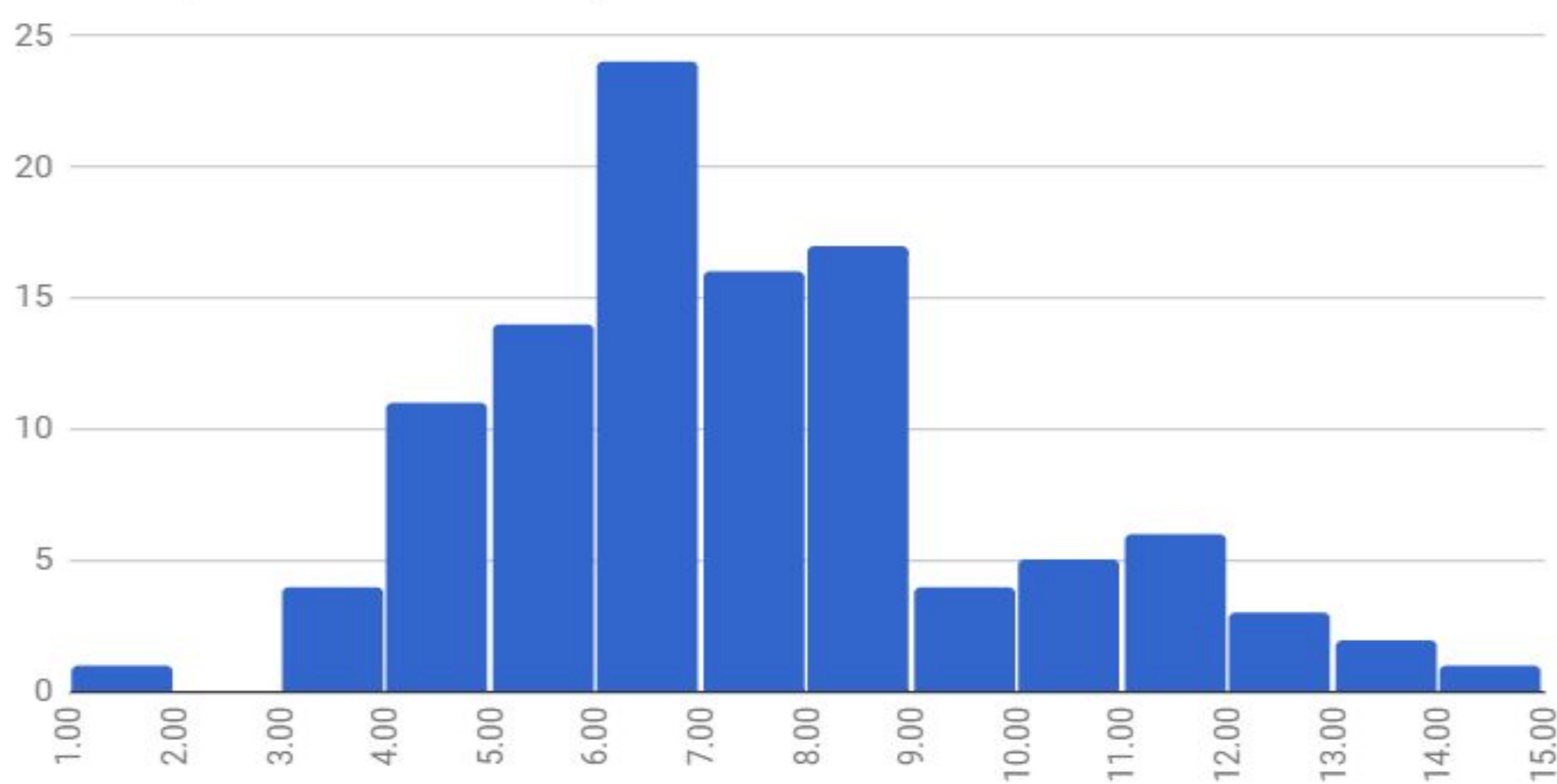
Clients' time homeless was mostly less than one year, though some had longer spans. As there are several outliers at the 300+ data points; it is unclear whether these reflect data inaccuracies or if indeed clients reported they've been homeless for 25+ years with a low VI-SPDAT.



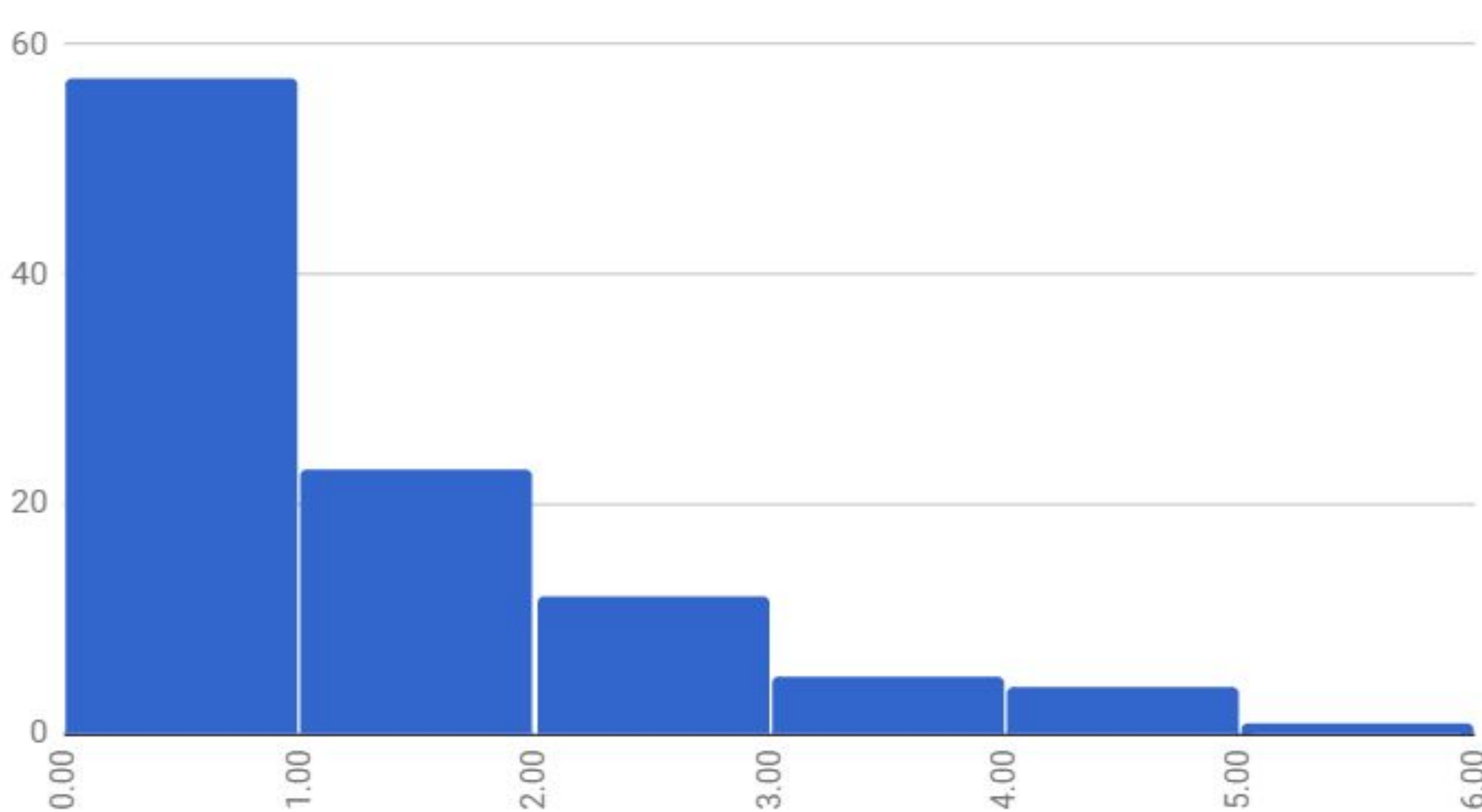
Days in program ranged from 0 to 2 to 75 days, though most were under 150 days. As the pilot project was ongoing, many of the participants would likely have stayed in program longer – possibly completing the 180-day support period.



The majority of program participants had one homelessness episode, though the range for a smaller number was up 13.



The acuity scores ranged 1 to 15, with most being in the 5-9 range.



Most who had dependents, reported one to two .

SUPPORTED REFERRALS, RAPID REHOUSING & HOUSING FIRST PROGRAM COMPARISON

Joined Data Set

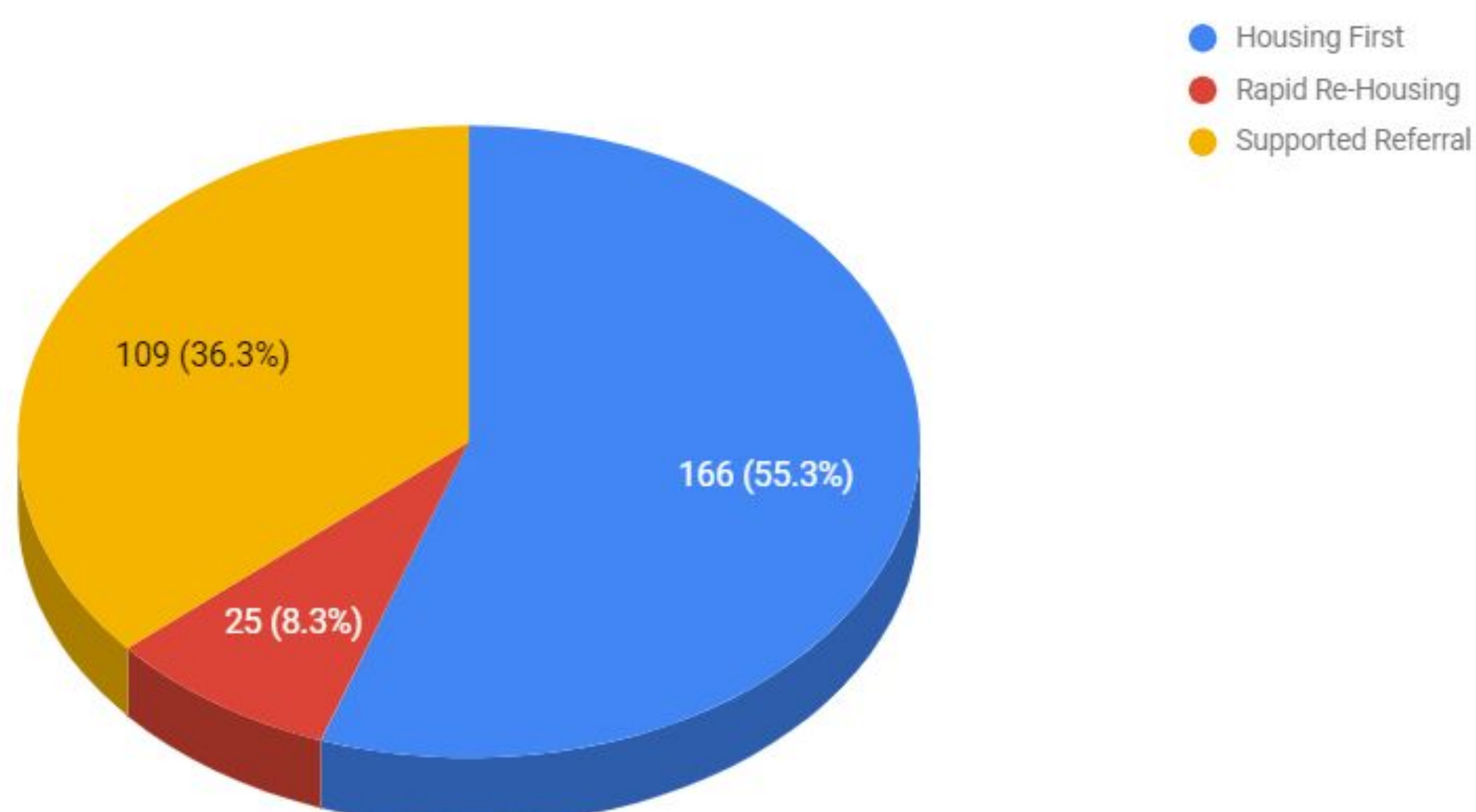
As previously mentioned, the SR, HF, and RRH data sets were joined to develop a larger sample for further comparative analysis. This was possible as both used the same variables and system (ETO) for collection.

Two ETO data sets from Supported Referral (n=109), RRH (n=25), and Housing First (n=166) from April 2017 to March 2018 were provided to the evaluator by Homeward Trust staff.

The rest of this section provides an overview of the results of the combined data set analysis from which we then present areas of statistically significant differences between the two groups. Appendix A provides charts showing overall trends in the joined-up data set as well.

It is important to note that the three program models being compared are different – to this end, we are not suggesting that points of differentiation are positive or negative; rather, the purpose of the analysis is to understand how the SR cohort differs on key program indicators in comparison to RRH and ICM.

Whereas RRH (like ICM/Housing First) reporting does include information on successful/unsuccessful exits from the program, the Supported Referral project does not. The SR participants are never in a program per se – the agencies report on their continued service provision to recipients of SR funding, and report monthly on the status of housing for each supported referral for the first six months after housing. Following that, agencies are no longer required to report on SR participants' housing status. Therefore, SR participants never enter or exit a separate program – rather, the agency continues to provide the support services it would otherwise have done; although, now they are doing so with a client housed through SR. The SR reporting period ends at six months.



Quantitative Variables

The average age in the sample was 42.5 years old, with 40.3 months homeless and 129 days in the program.

The VI-SPDAT score was about 10 and average numbers of days from intake to housing was 56.

	Days in program	Time from Intake to Housing	Age	VI-SPDAT score	Months homeless
Count	275	279	300	299	296
Mean	129.0	55.7	42.5	9.5	40.3
Min	0	0	19	1	0
Q1	78	11	33	7	12
Median	126	34	41	10	24
Q3	179	88	52	12	49
Max	326	387	77	16	420
Standard deviation	70	58	13	3	58
Coefficient of variation	54.0%	103.8%	29.5%	33.5%	144.8%
Skewness	0.31	1.59	0.23	-0.16	3.72

Correlation Results

Correlation coefficients results are presented below. The basic findings here are that a higher VI-SPDAT score is correlated to longer times from intake to housing. Less-evident correlations include VI-SPDAT score, months homeless, and days in the program.

	Days in program	Time from Intake to Housing	Age	VI-SPDAT score	Months homeless
Days in program	1				
Time from Intake to Housing	-0.007	1			
Age	0.055	0.041	1		
VI-SPDAT score	0.110	0.228	0.052	1	
Months homeless	0.019	0.061	0.066	0.087	1

Significant Relations

Significant relations among variables are summarized below for the data set.

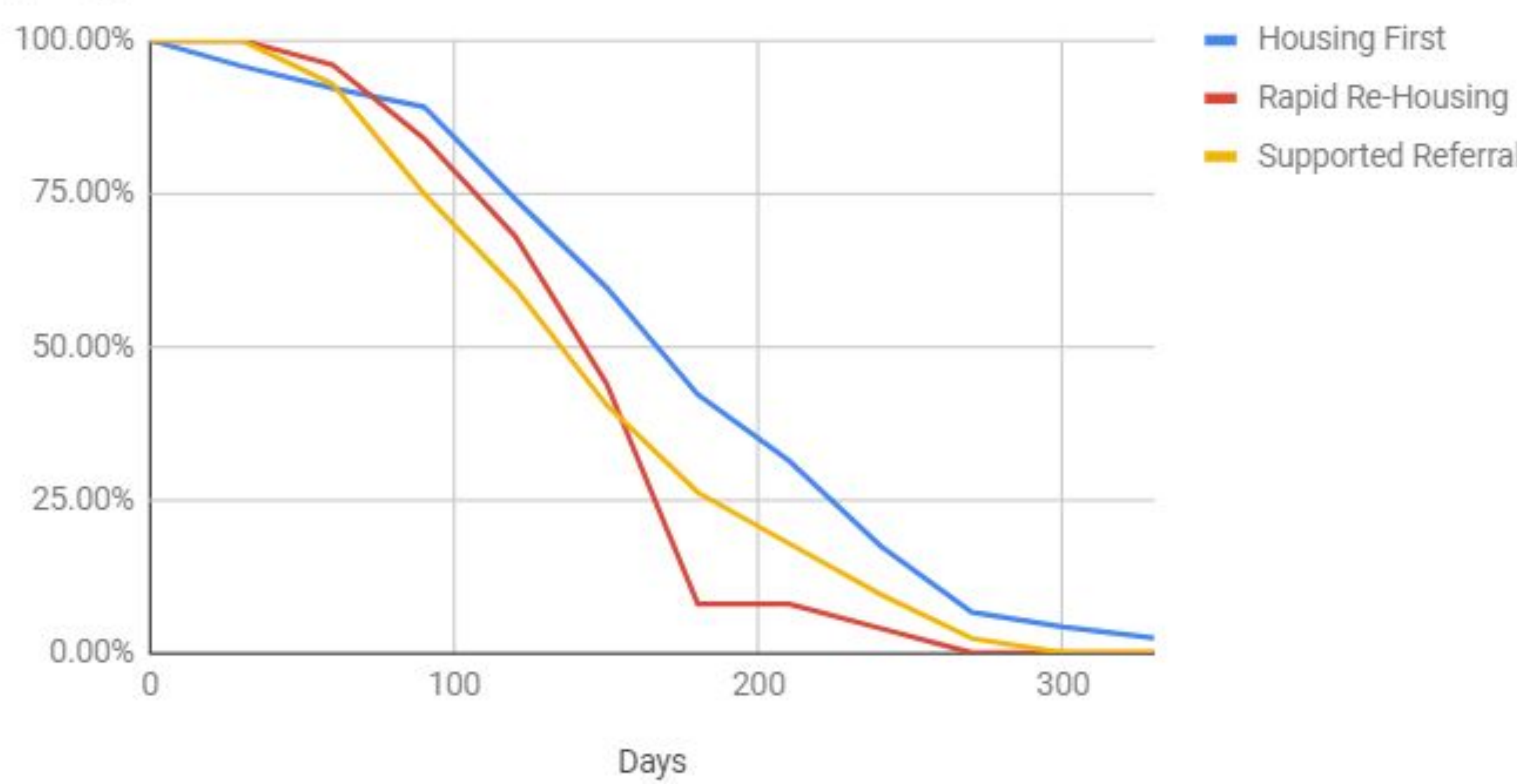
Variable 1	Variable 2	P-value	Notes
Current location	Age	0.004	Outdoors clients are older
Current location	Dependent	0.000	No dependents for those from outdoors
Current location	Ethnicity	0.009	For Couchsurfing clients have a higher ratio of Aboriginal and smaller Caucasian incidence
Current location	Gender	0.006	Outdoors clients are mostly men
Current location	Program name	0.000	Outdoors clients are mostly in Housing First, rarely in Supported Referrals
Current location	Time from Intake to Housing	0.003	Those from outdoors have longer time from intake to housing
Current location	VI-SPDAT score	0.000	Higher VI-SPDAT for outdoors clients
Dependent	Age	0.000	Younger clients have more dependents
Dependent	Days in program	0.010	Smaller number of days in program if client has dependents
Dependent	Gender	0.000	Dependent connected with female clients
Dependent	Months homeless	0.000	Less time homeless for clients with dependents
Dependent	Time from Intake to Housing	0.000	Shorter time from intake to housing for clients with dependent
Dependent	VI-SPDAT score	0.000	Smaller VI-SPDAT score for clients with dependent
Ethnicity	Age	0.009	Inuit clints are older. NOTE: this is a small sample
Ethnicity	Gender	0.001	Caucasian are most often men; Aboriginal most often women
Ethnicity	VI-SPDAT score	0.002	Métis have VI-SPDAT higher score. NOTE: small sample
Gender	Age	0.000	Men are older
Gender	Months homeless	0.002	Men are homeless longer
Gender	VI-SPDAT score	0.015	Men have a higher VI-SPDAT score
Program name	Days in program	0.005	Longer stays in Housing First programs
Program name	Dependent	0.000	Dependents in SR programs
Program name	Ethnicity	0.000	For Rapid Re-Housing, higher ratio of First Nations and smaller of Caucasian. In Housing First, smaller ratio of Aboriginal.
Program name	Gender	0.000	In SR more women; Housing First, mostly men
Program name	Months homeless	0.038	Fewer months in SR programs
Program name	Time from Intake to Housing	0.000	Short time for SR programs
Program name	VI-SPDAT score	0.000	High score for Housing First programs

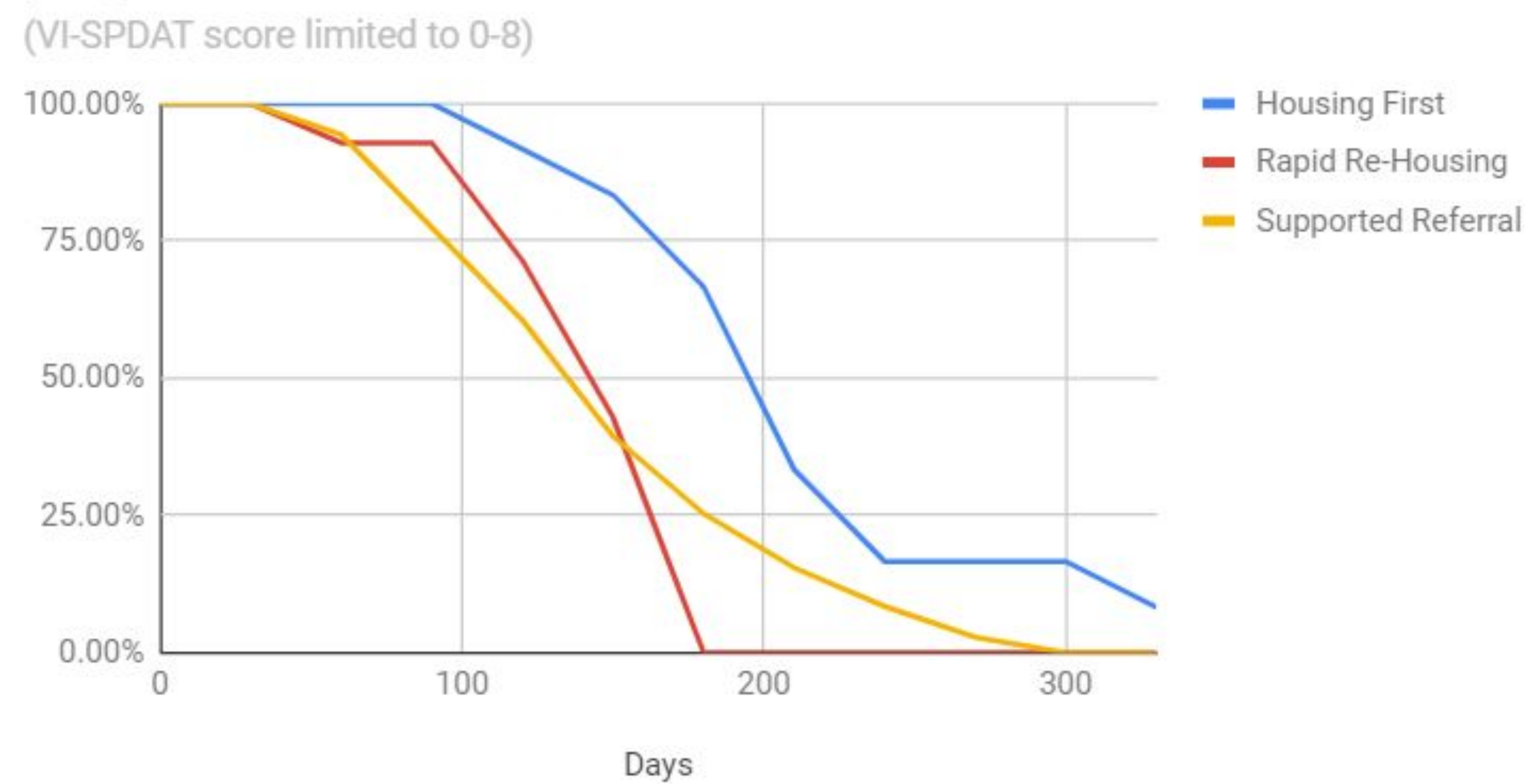
Days in Program

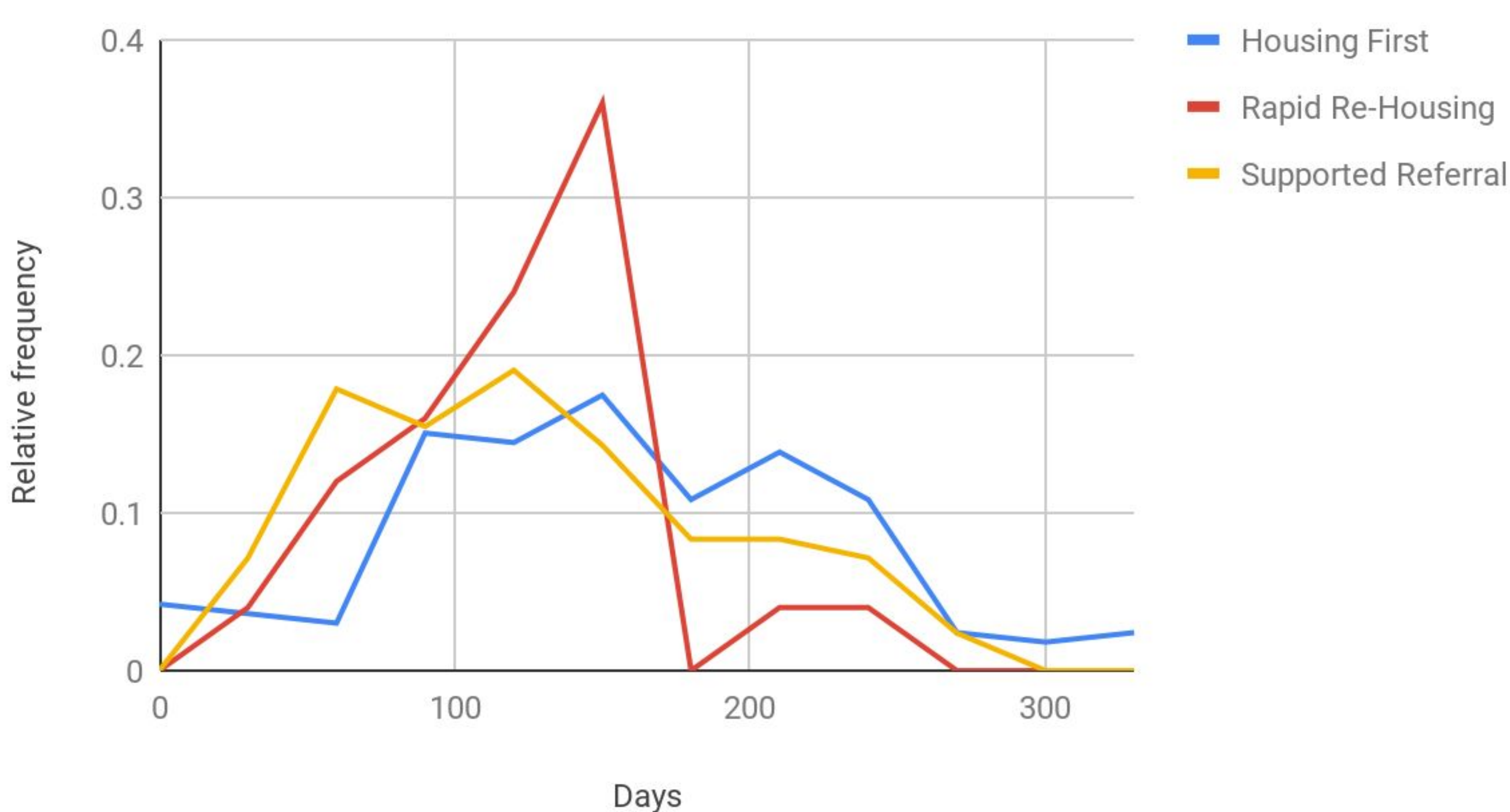
Looking closer at the fact that RRH and ICM programs have specific service models is needed. As of April 2017, RRH is a three-month program; prior to that it was a six-month program. So, RRH participants will likely exit the program after around three months. ICM is a 12-month program and participants are therefore likely to leave the program around this point. As a result, direct comparisons of drop-off rates across programs are challenging.

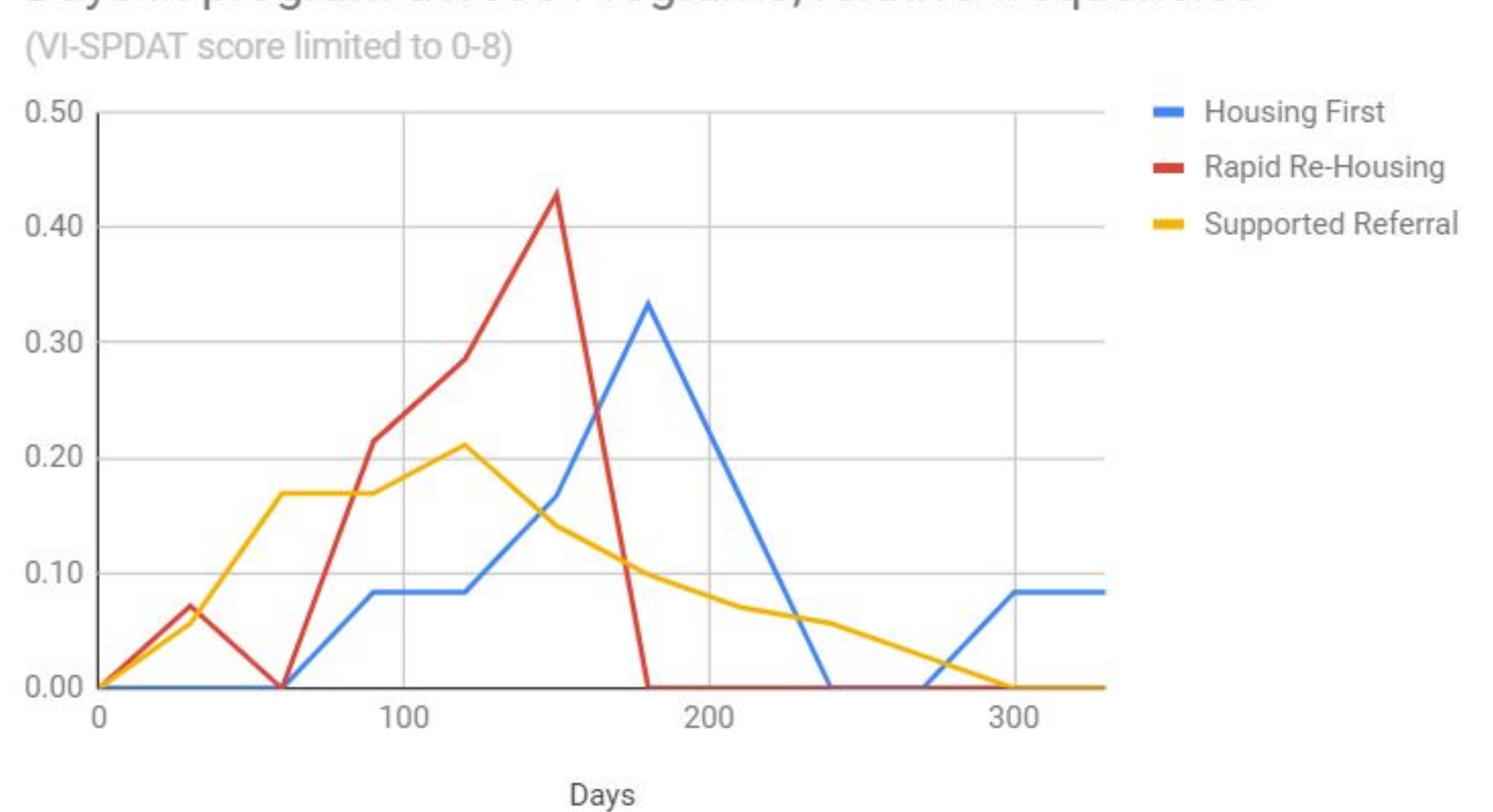
To this end, we generated a very specific comparison of housing stability over time for participants of similar acuity examining housing retention trends for people receiving SR and those in ICM/RRH programs. A VI-SPDAT acuity range of 0-8, based on the project guidelines with exceptions.

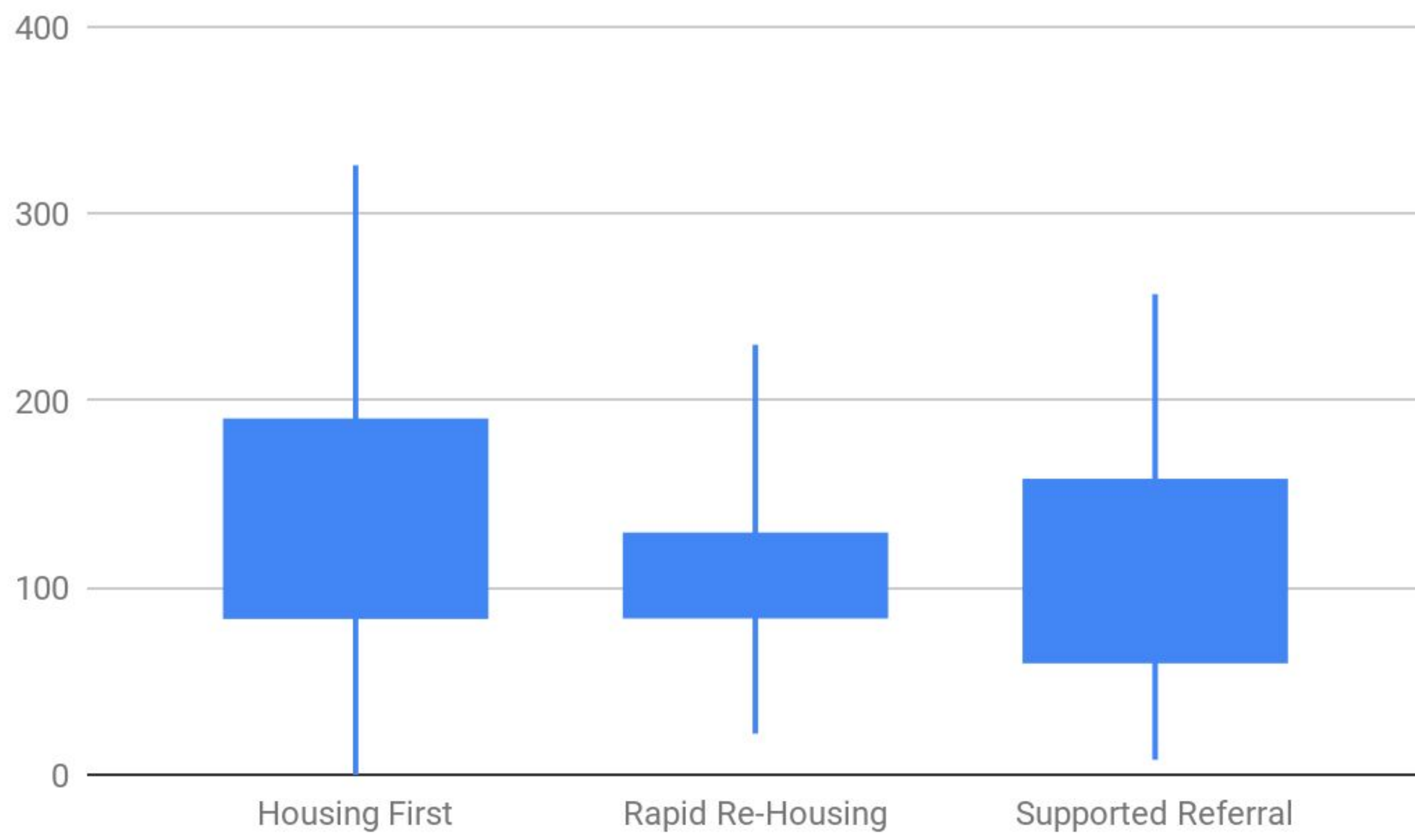
As the graphs below suggest, when comparing lower acuities, we see drop-offs from RRH at about 180 days compared to 280 for all acuities.



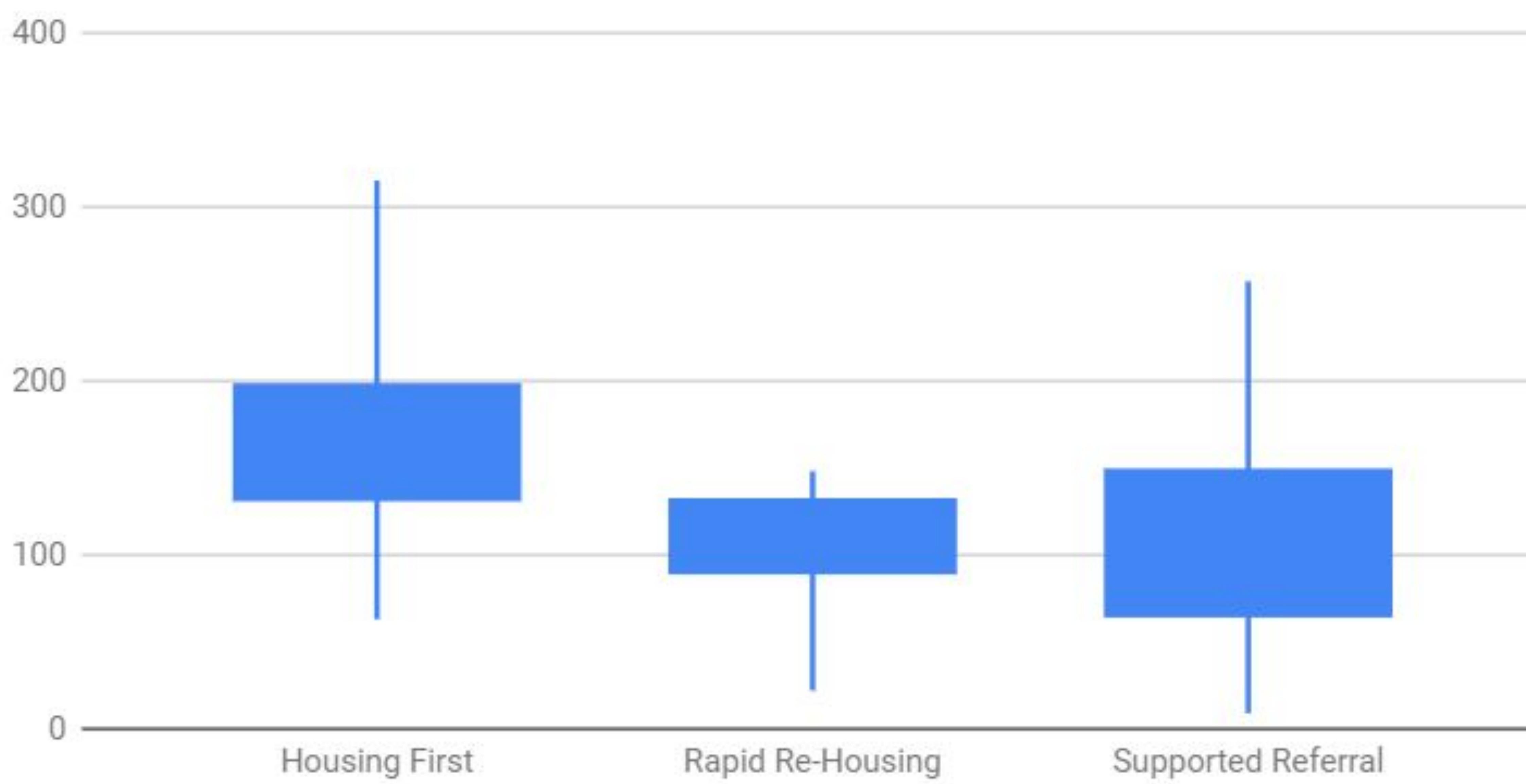








The range of SR client days-in-program spans longer than that of RRH clients, but less than HF clients.



Looking at lower acuities, the days for RRH are around the 90-110 day mark, compared to 110-200 for Housing First, and 80-130 for SR.

SR clients are staying the programs longer than RRH but less than HF clients during the initial 3 months:
- at 30 days, 100% of SR, RRH and Housing First ICM clients were still enrolled;
- at 60 days, 93% of SR clients were still enrolled, compared to 96% for RRH and 92% in HF;
- at 90 days, 75% of SR clients were still enrolled, compared to 84% for RRH and 89% in HF.

Days in Program - All Acuties

Days	Housing First	Rapid Re-Housing	Supported Referral
0	100.00%	100.00%	100.00%
30	95.78%	100.00%	100.00%
60	92.17%	96.00%	92.86%
90	89.16%	84.00%	75.00%
120	74.10%	68.00%	59.52%
150	59.64%	44.00%	40.48%
180	42.17%	8.00%	26.19%
210	31.33%	8.00%	17.86%
240	17.47%	4.00%	9.52%
270	6.63%	0.00%	2.38%
300	4.22%	0.00%	0.00%
330	2.41%	0.00%	0.00%

Looking at lower acuity clients only during the initial 3 months:
- at 30 days, 100% of SR, RRH and Housing First ICM clients were still enrolled;
- at 60 days, 9% of SR clients were still enrolled, compared to 72% for RRH and 78% in HF;
- at 90 days, 4% of SR clients were still enrolled, compared to 40% for RRH and 54% in HF.

This suggests that when comparing similar acuities, most SR participants drop off sooner than the other programs at 90 days, compared to 150 days for RRH, and 210 days for Housing First.

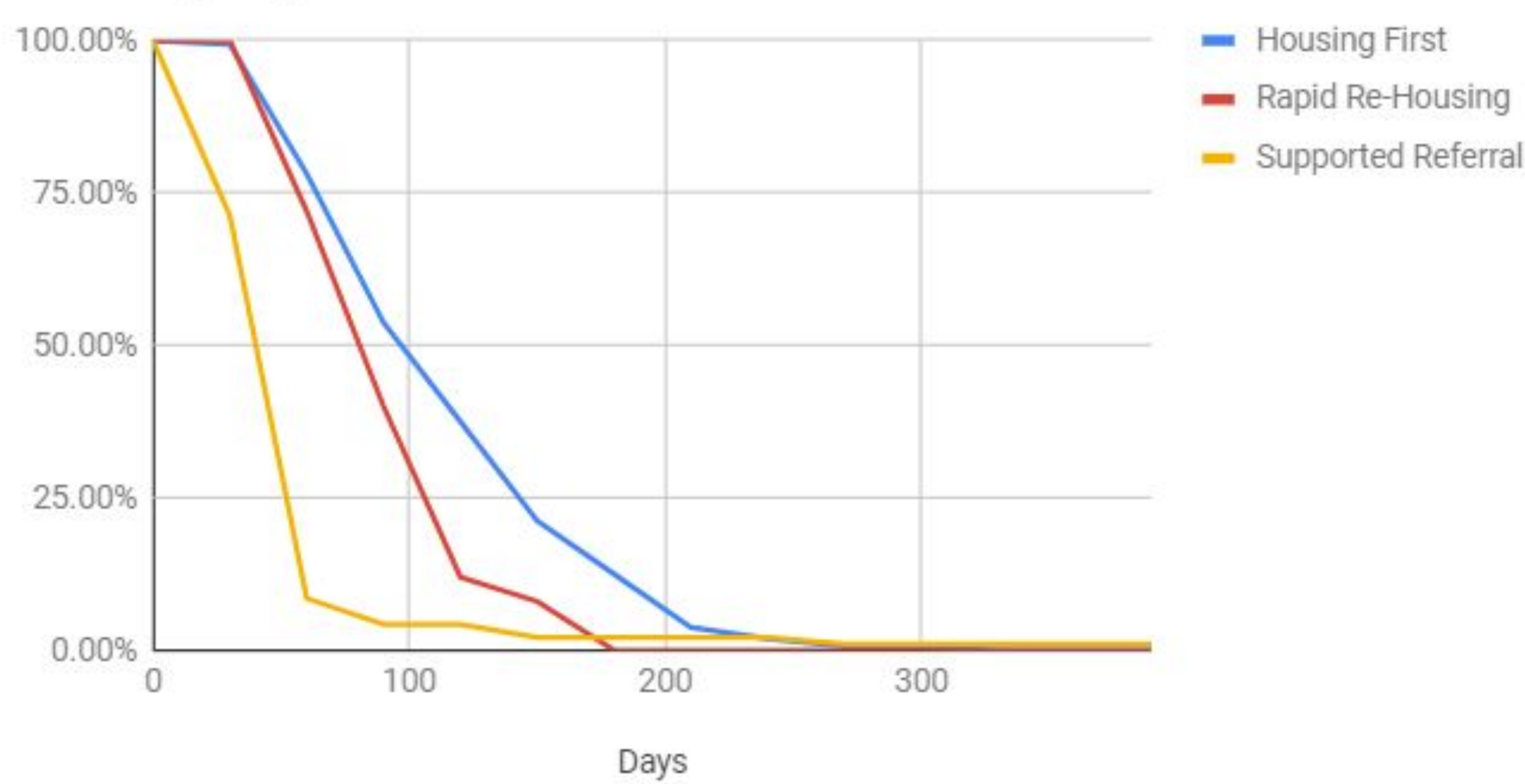
Days in Program – Low Acuties (VI-SPDAT 0-8)

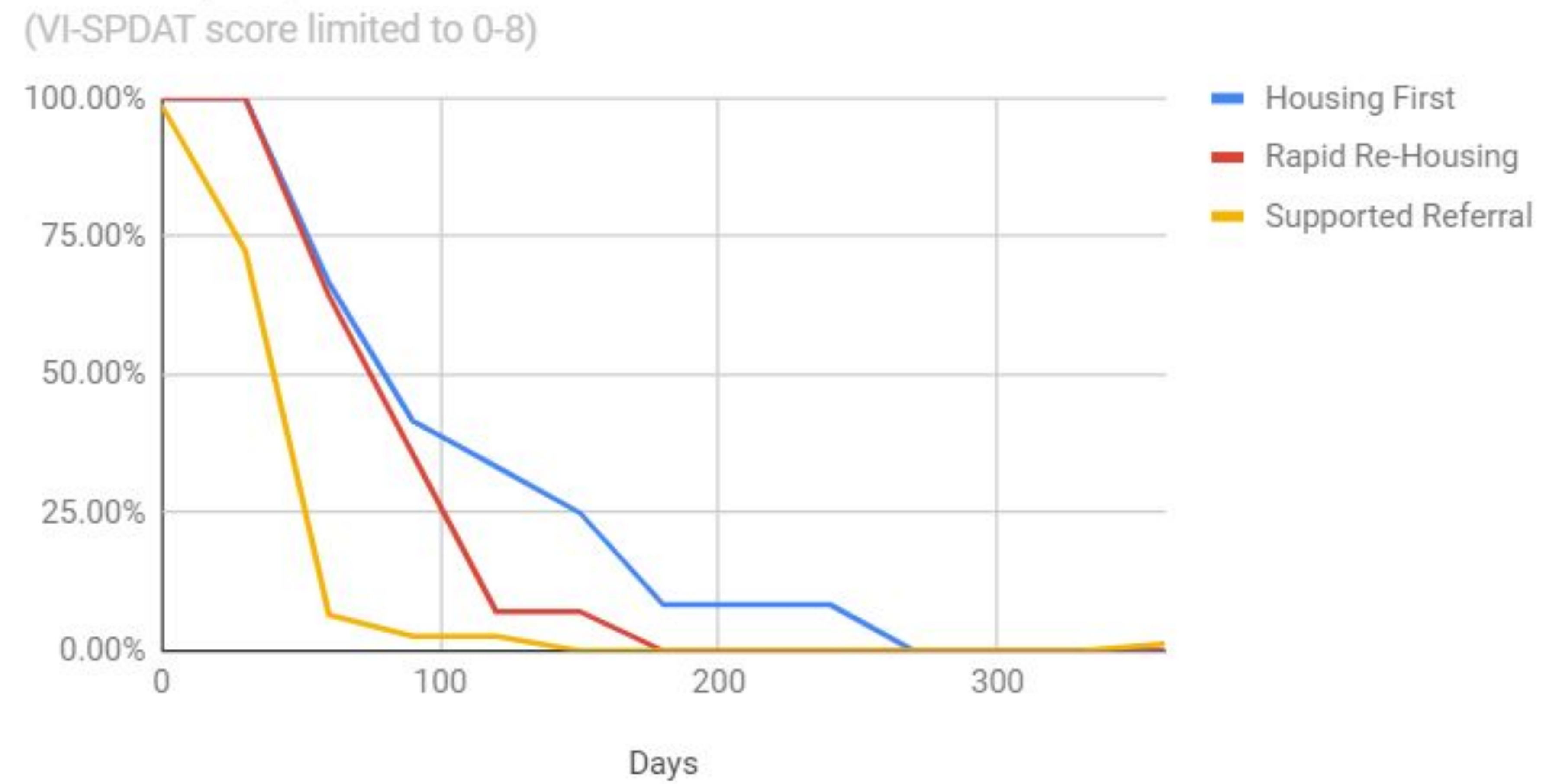
Days	Housing First	Rapid Re-Housing	Supported Referral
0	100.00%	100.00%	100.00%
30	99.38%	100.00%	71.28%
60	78.13%	72.00%	8.51%
90	53.75%	40.00%	4.26%
120	37.50%	12.00%	4.26%
150	21.25%	8.00%	2.13%
180	12.50%	0.00%	2.13%
210	3.75%	0.00%	2.13%
240	1.88%	0.00%	2.13%
270	0.63%	0.00%	1.06%
300	0.63%	0.00%	1.06%
330	0.00%	0.00%	1.06%
360	0.00%	0.00%	1.06%
390	0.00%	0.00%	1.06%

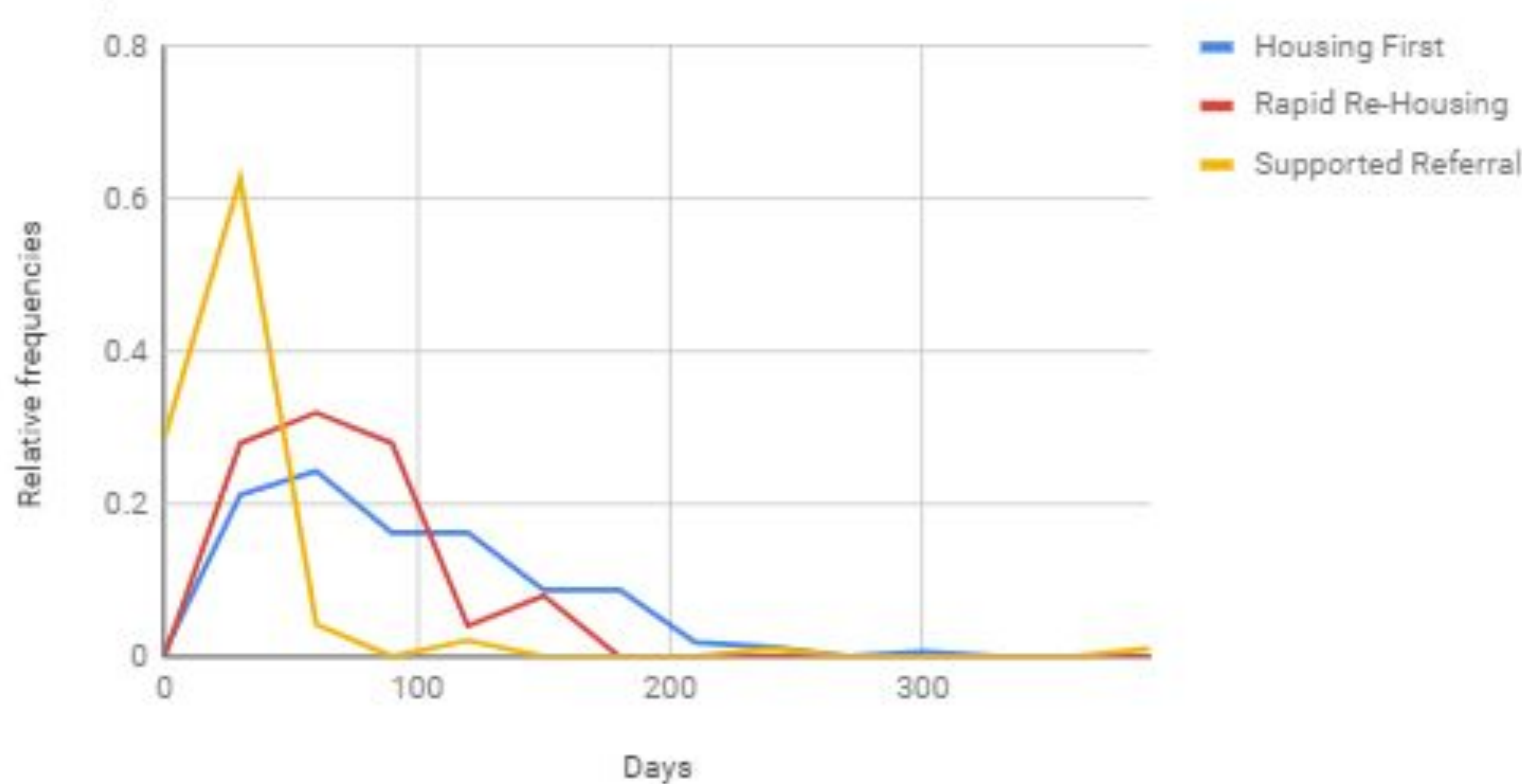
Time from Intake to Housing

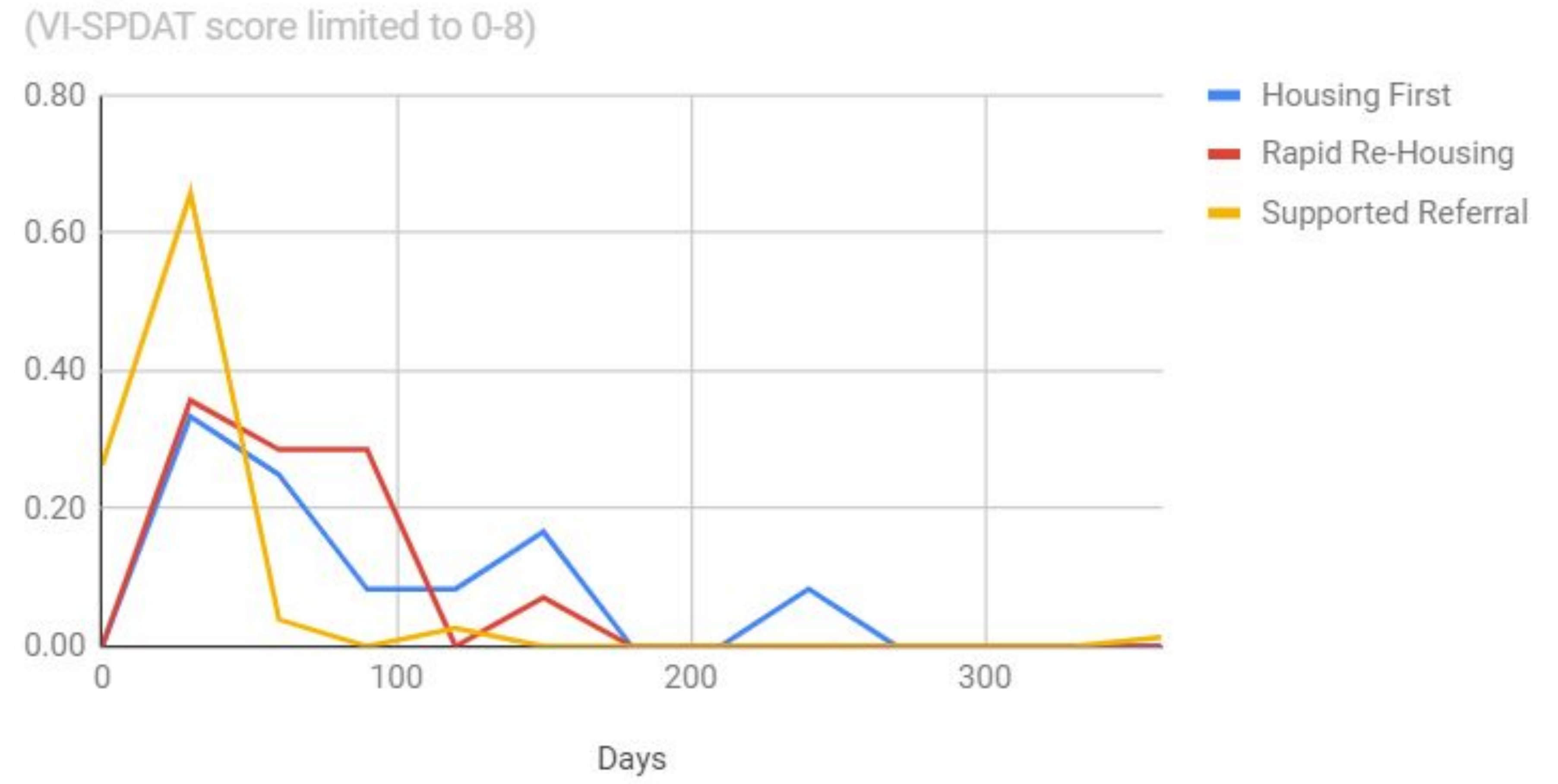
When comparing the time from Intake to Housing across the program types, SR clients waited less time than those in RRH and HF programs as evident in the figure below; however, there was a small percent of clients who 'trailed' from 150-390 days in the SR sample compared to RRH and HF. The natural drop-off for SR seems to be 60 days, after which 4% or less of clients are waiting for up to 390 days. This drop-off occurs at 150 days for RRH, and 180 days for HF programs.

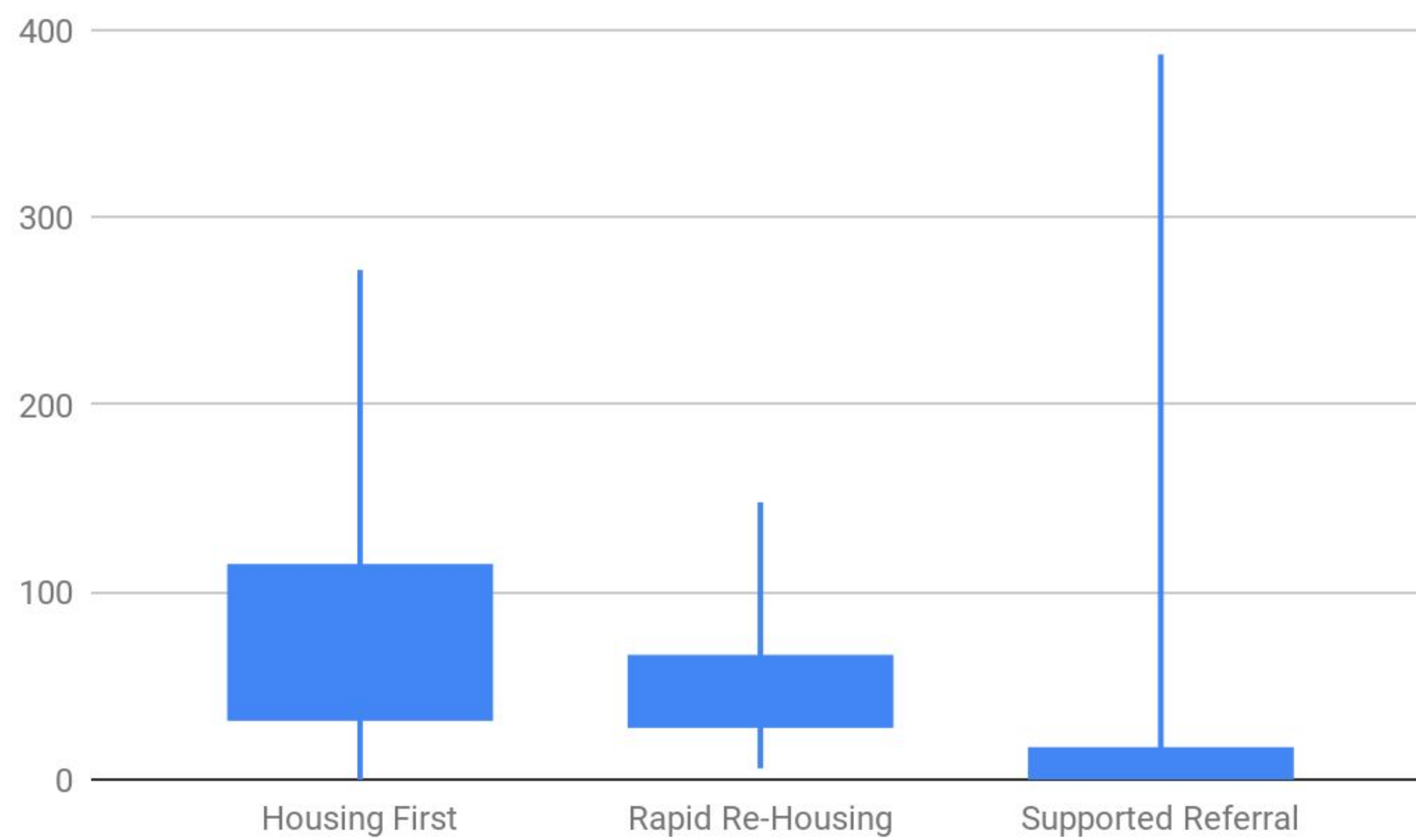
When comparing lower acuities only, a main difference is that SR seem to have shorter times than RRH and HF than for the full sample. This is more pronounced when we look at the sub-sample.



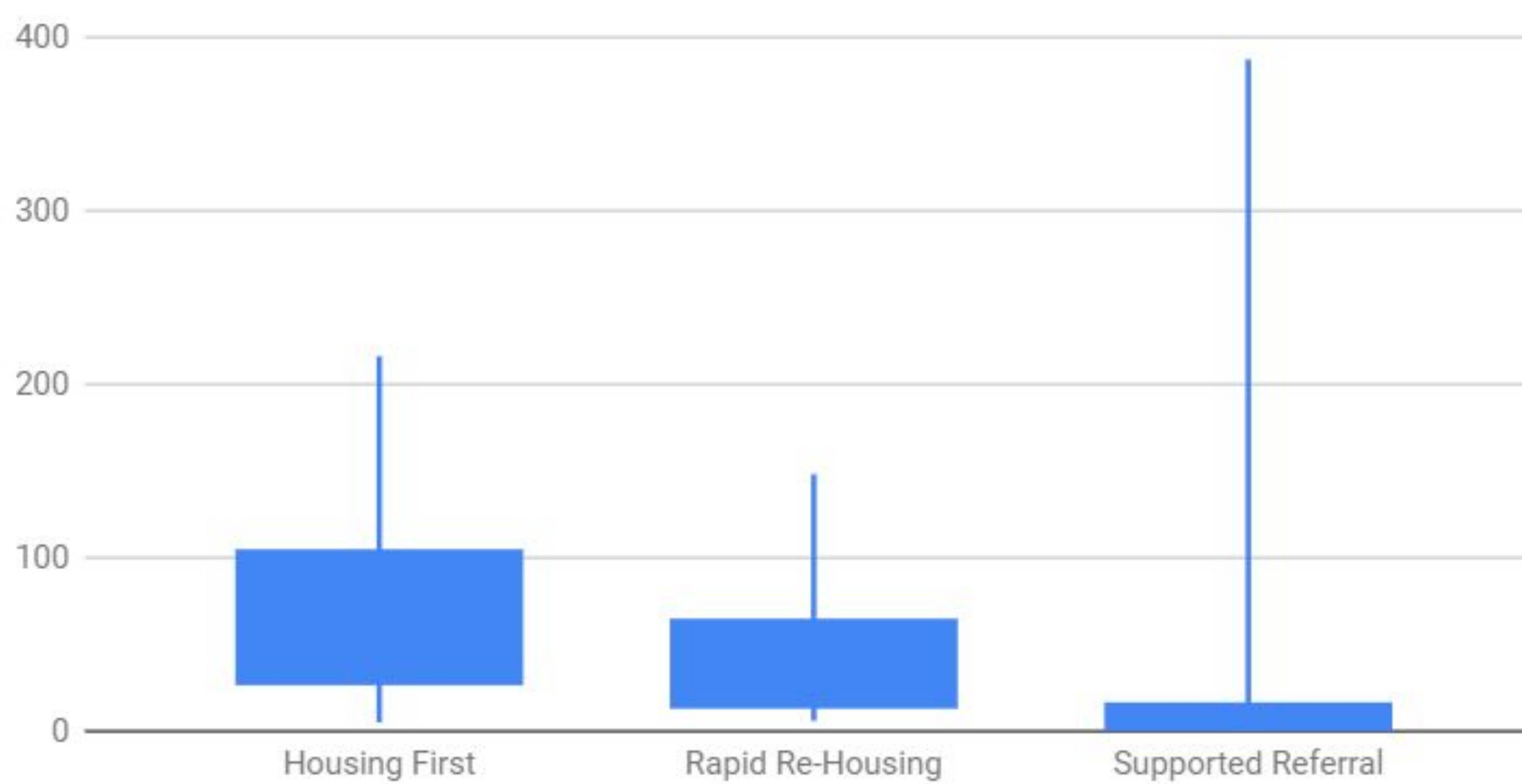




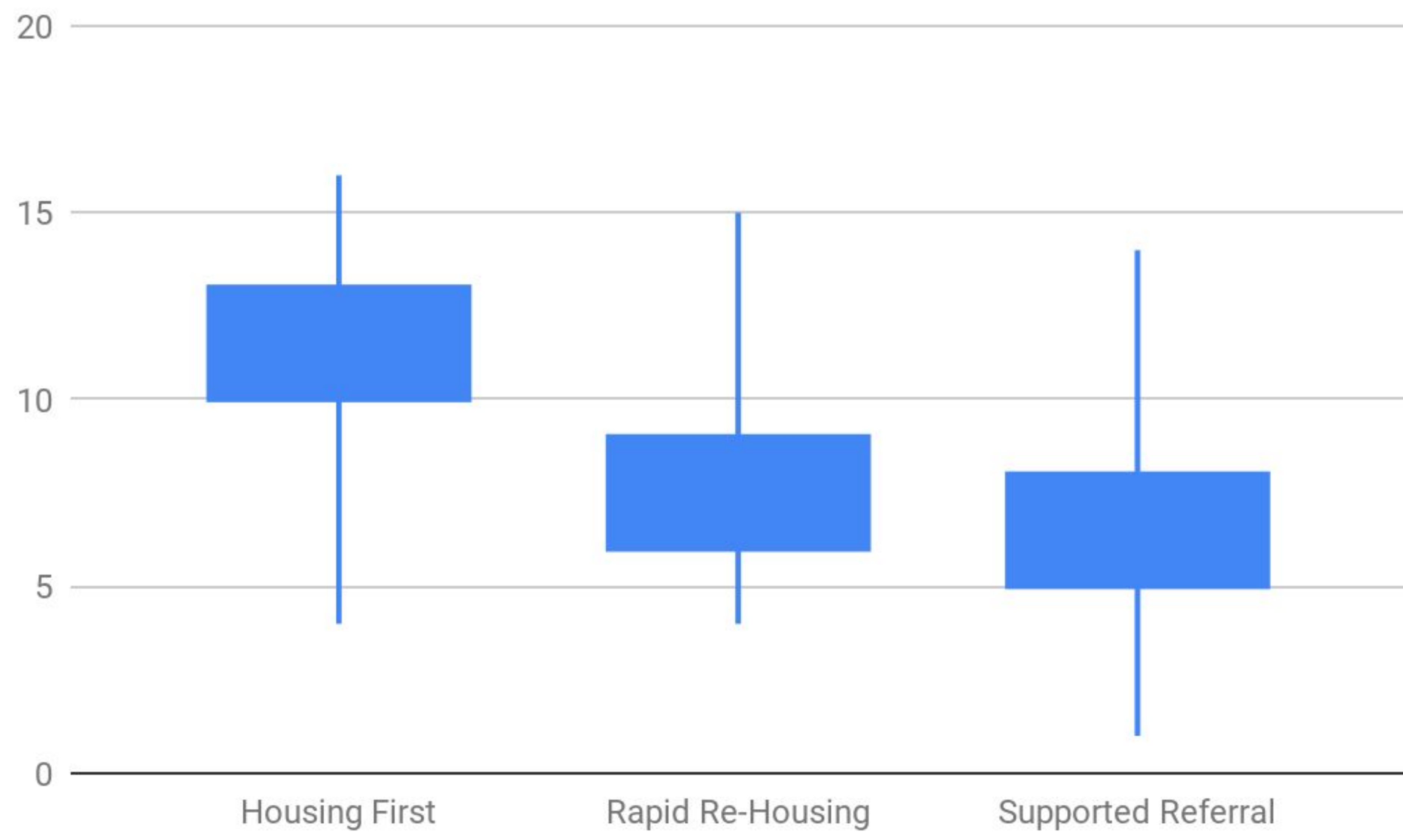




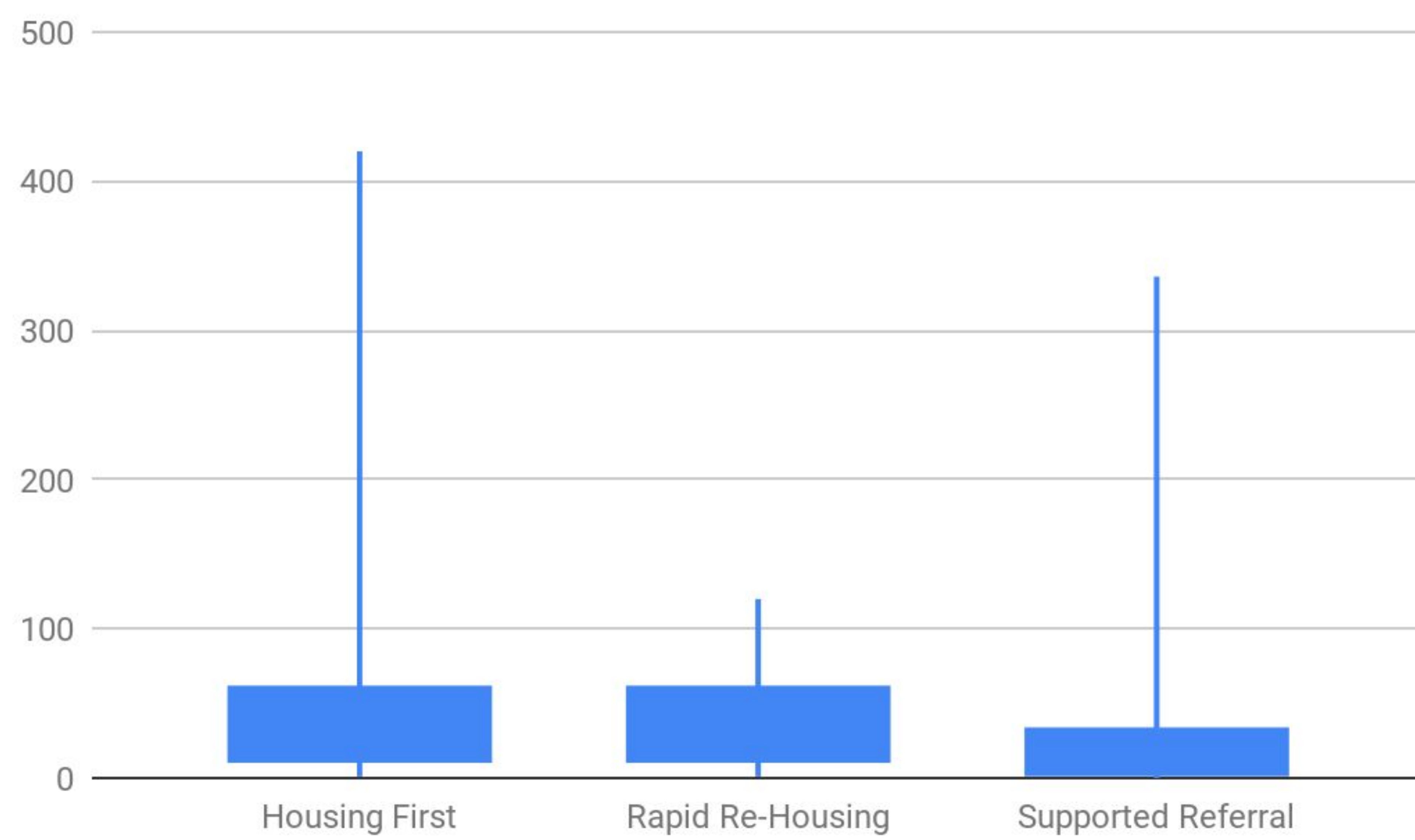
SR clients are waiting less time between intake and housing than RRH and HF clients.



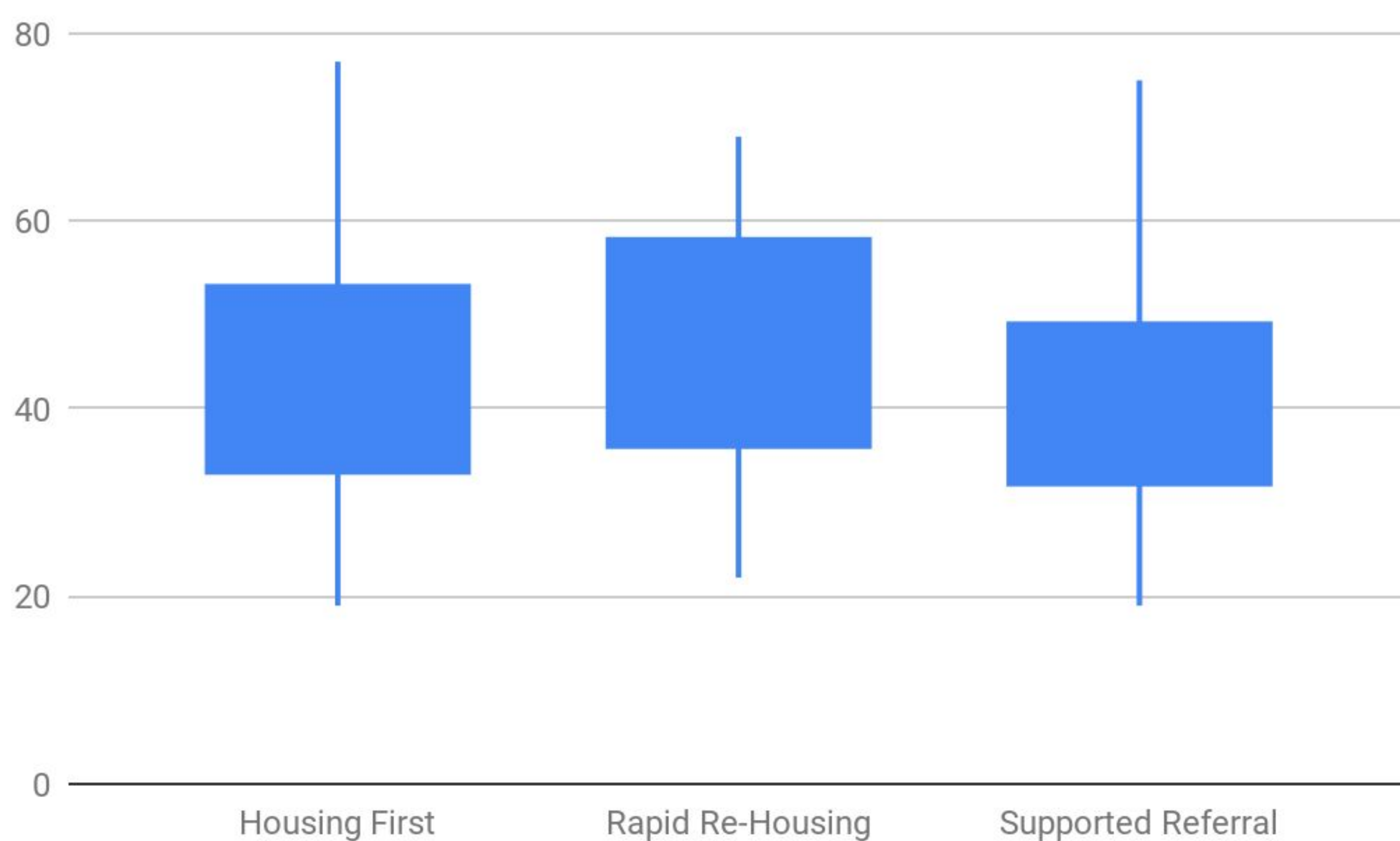
Comparing lower acuities, the HF time decreases slightly, RRH trends down as well while SR time is close to zero in both cases.



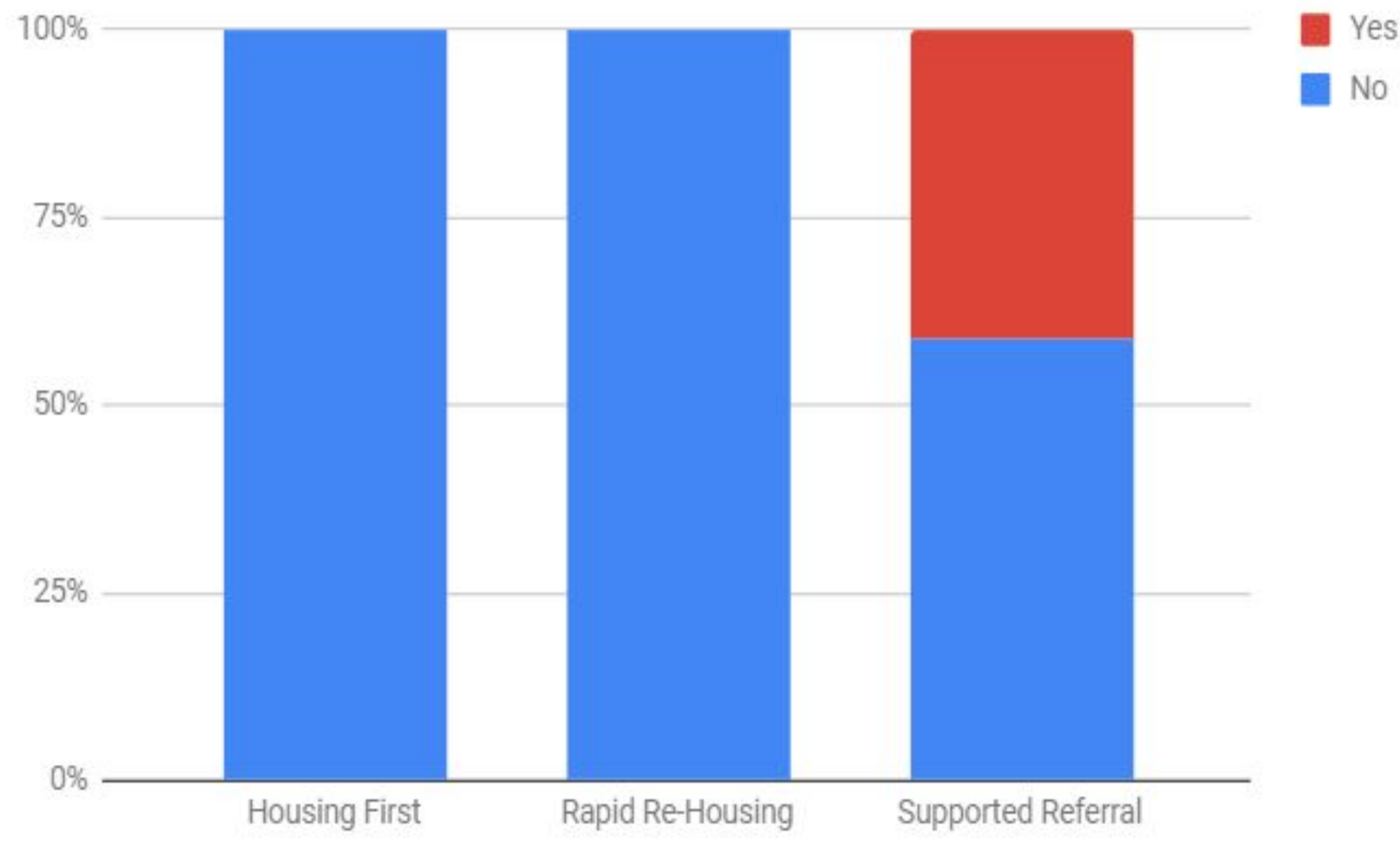
SR clients have lower scores than RRH and HF clients.



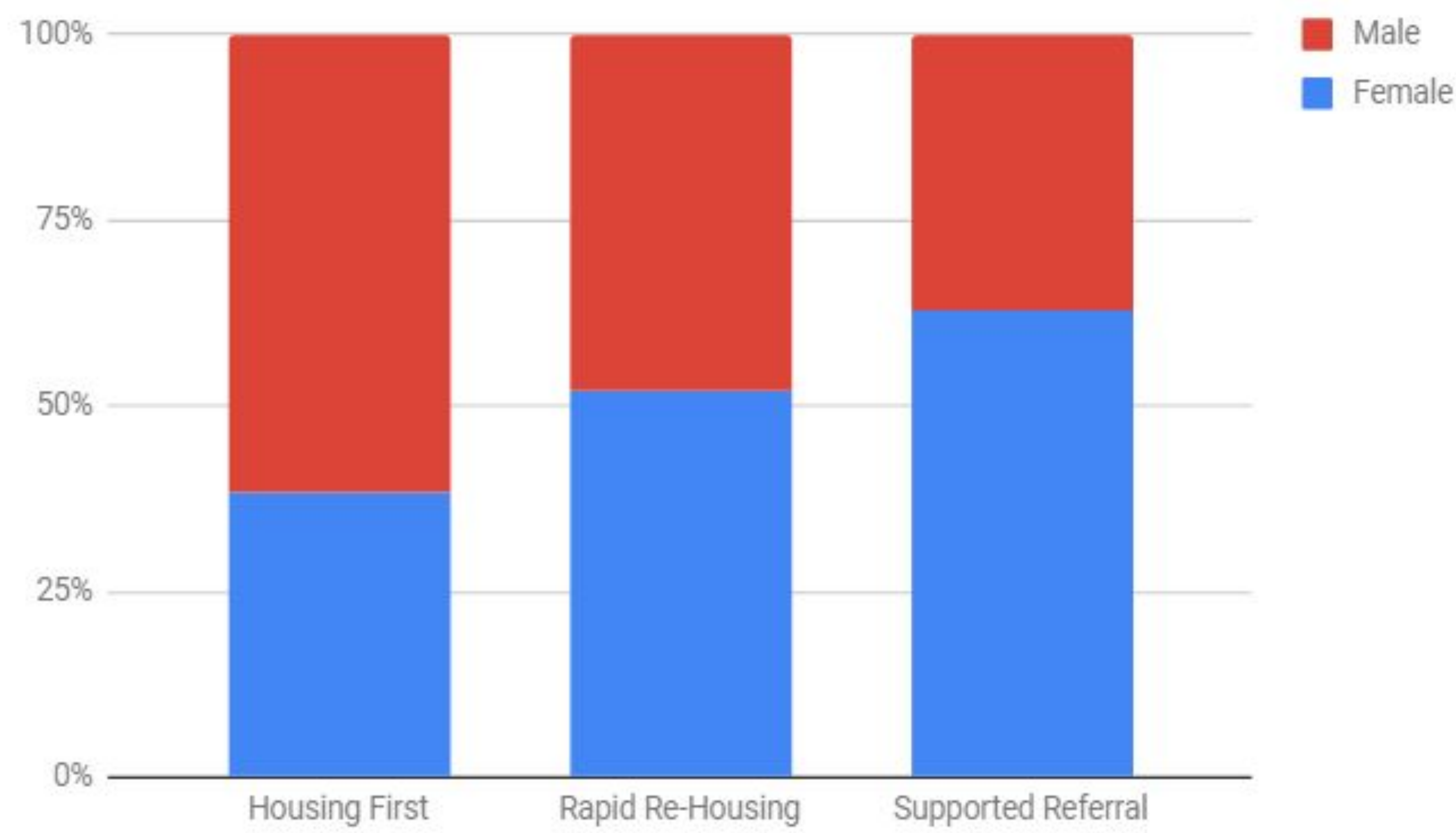
SR clients have lower acuity scores thant RRH and HF clients.



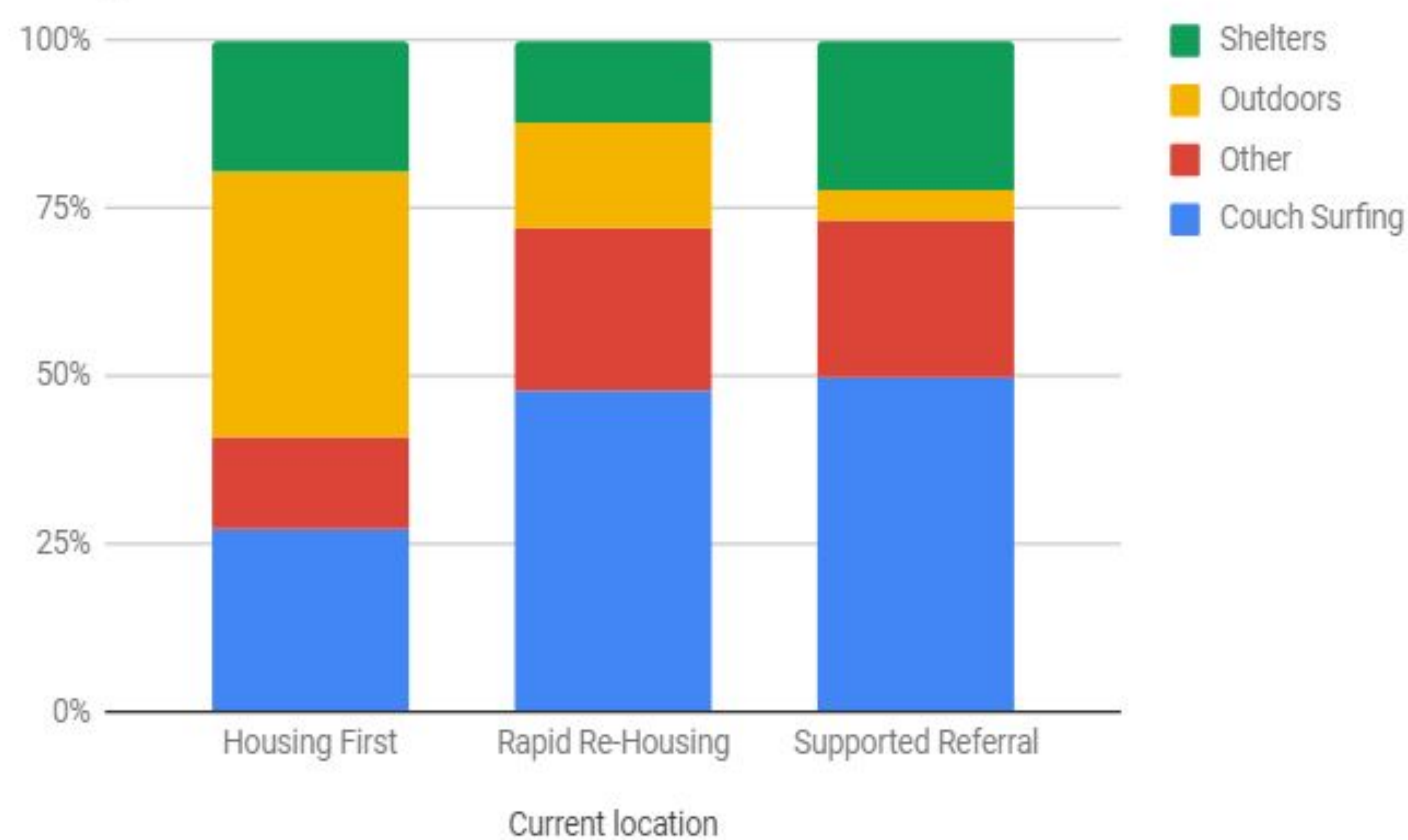
SR clients are younger than RRH and HF clients.



SR clients have dependents; RRH and HF clients do not.



More SR clients are female compared to RRH and HF.



More SR clients come from shelters and couchsurfing compared to RRH and HF. Fewer come from outdoors.

COSTS ANALYSIS

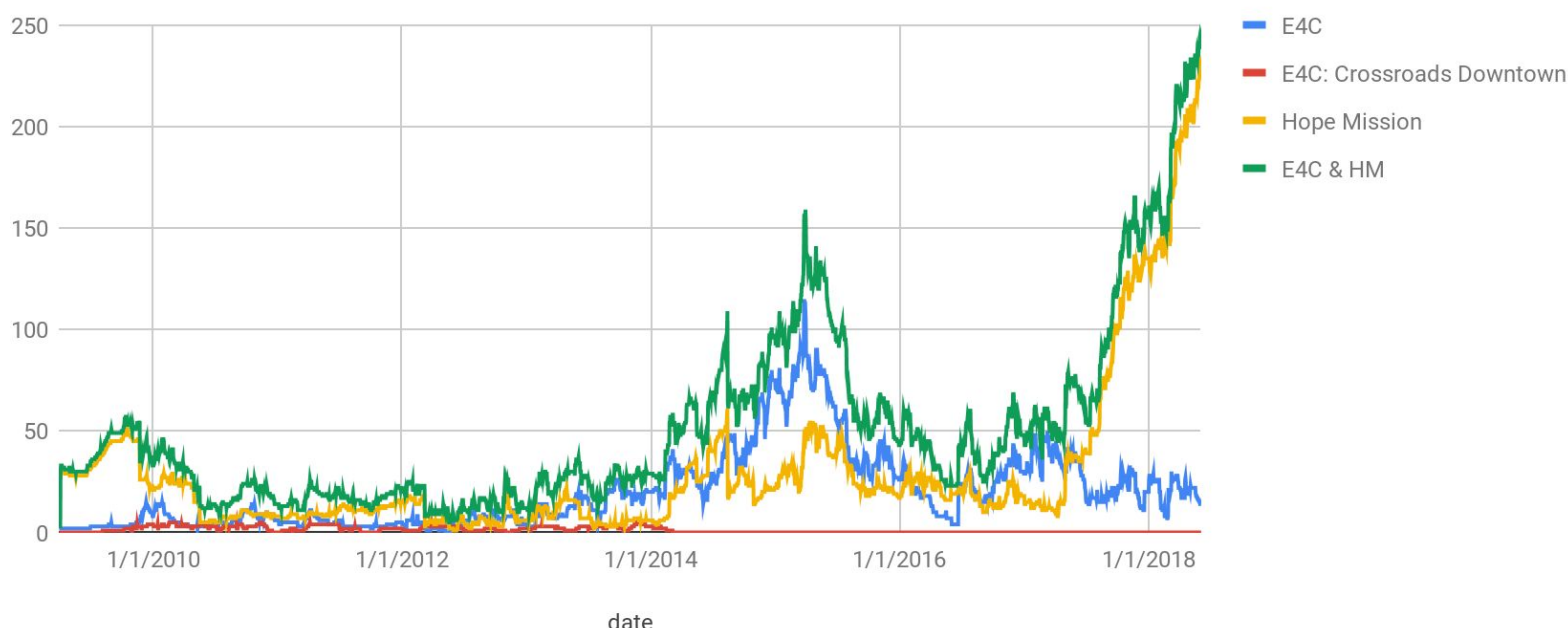
Financial information provided by HTE differed how expenses were recorded between the SR and 2 RRH programs (Hope Mission, E4C). This makes accurate comparison among cost categories difficult; as such, averages were calculated overall.

In examining the number of clients supported at any point in time in the program, a daily average was calculated among the sample. Using this figure against actuals, the total monthly spent in **RRH was $1,265/client supported** compared to **$230 for SR clients.** When broken down by client startup costs only, it is worth noting these are relatively equal.

While this would suggest that the RRH programs are more expensive than SR programs, given how different the nature of services offered and the target population is, it would be a misleading comparison. RRH programs offer financial and case management services and landlord supports, whereas SR programs are primarily a financial or furniture benefit with support services offered by participating agencies through existing budgets not accounted for the in the calculation.

	Supported Referrals	**Rapid Rehousing**
	Actual	HM & E4C only
Costs	$ 131,268.58	$ 1,948,732.16
Months of data	6	22
Monthly costs	$ 21,878.10	$ 88,578.73
Average # people a day in program	95	**70***
Monthly costs/ # people served	$ 230.30	$ 1,265.41

* Number calculated on the basis of sites E4C and Hope Mission listed in the 'Clients housed in HF 2009-2018' tab of the following file https://docs.google.com/presentation/d/1ldsQcOAynFgHtcGvgLz82J6wonX2wfskRkLxCjUeClQ/edit#slide=id.g3daf5897c4_0_0



CLIENT STARTUP COSTS

Client startup (CSU) costs for the first 90 days are the most directly comparable costs between Rapid Rehousing financials and Supported Referral financials.

Client Startup (CSU) costs for SR were compared to CSU for RRH over the July – December 2017 period (the period for which finances are available for the SR project).

Important to note when using CSU costs is that multiple costs can be associated with one participant. Therefore, when calculating the number of people housed on an RRH program, duplicate ID numbers had to be removed.

The results suggest that the CSU costs are about 50% lower for SR clients compared to RRH during the first 90 days of program enrollment ($1,228 vs. $1,846). This might be related to the way CSU is being coded and eligibility for other financial supports from the programs; This will need to be explored further.

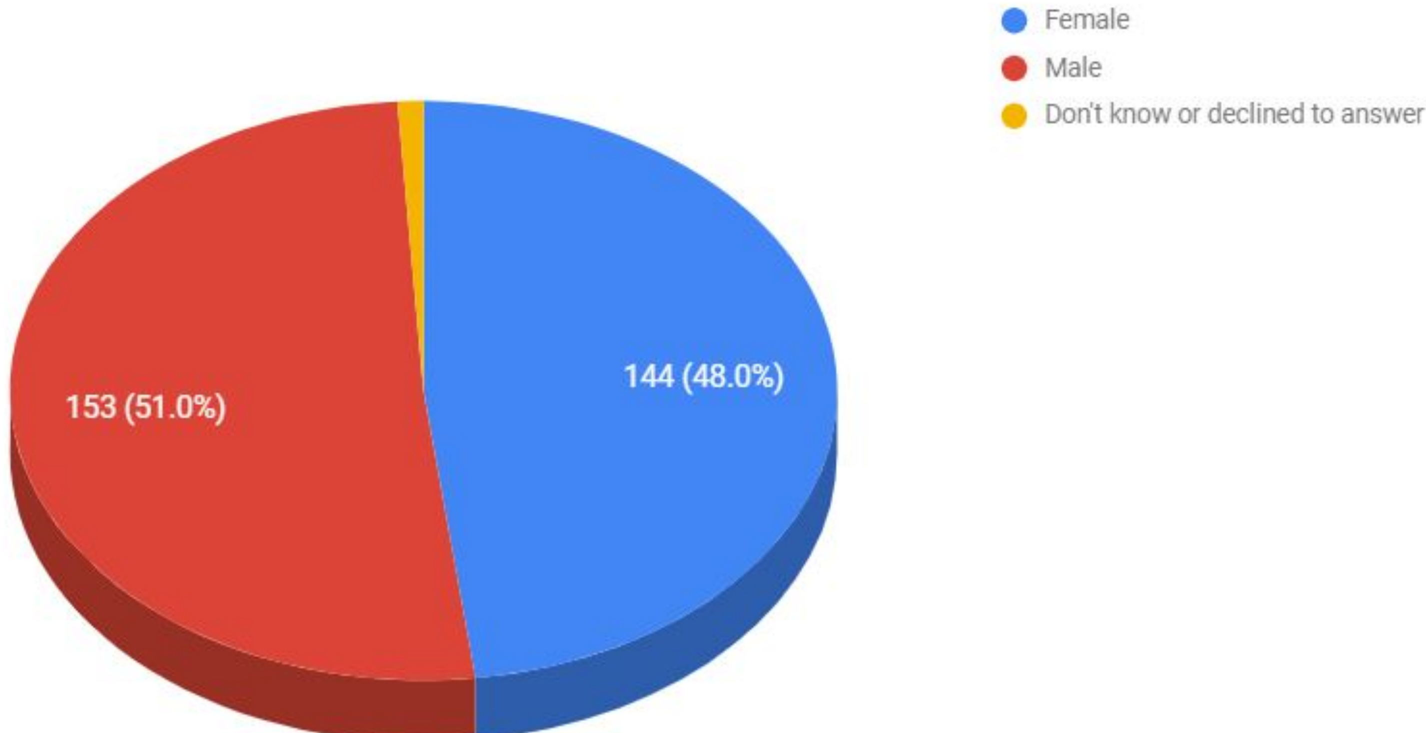
A key limitation is that HTE was not able to provide ETO numbers for SR costs in the same manner they did for HM and E4C, which impacts comparability again.

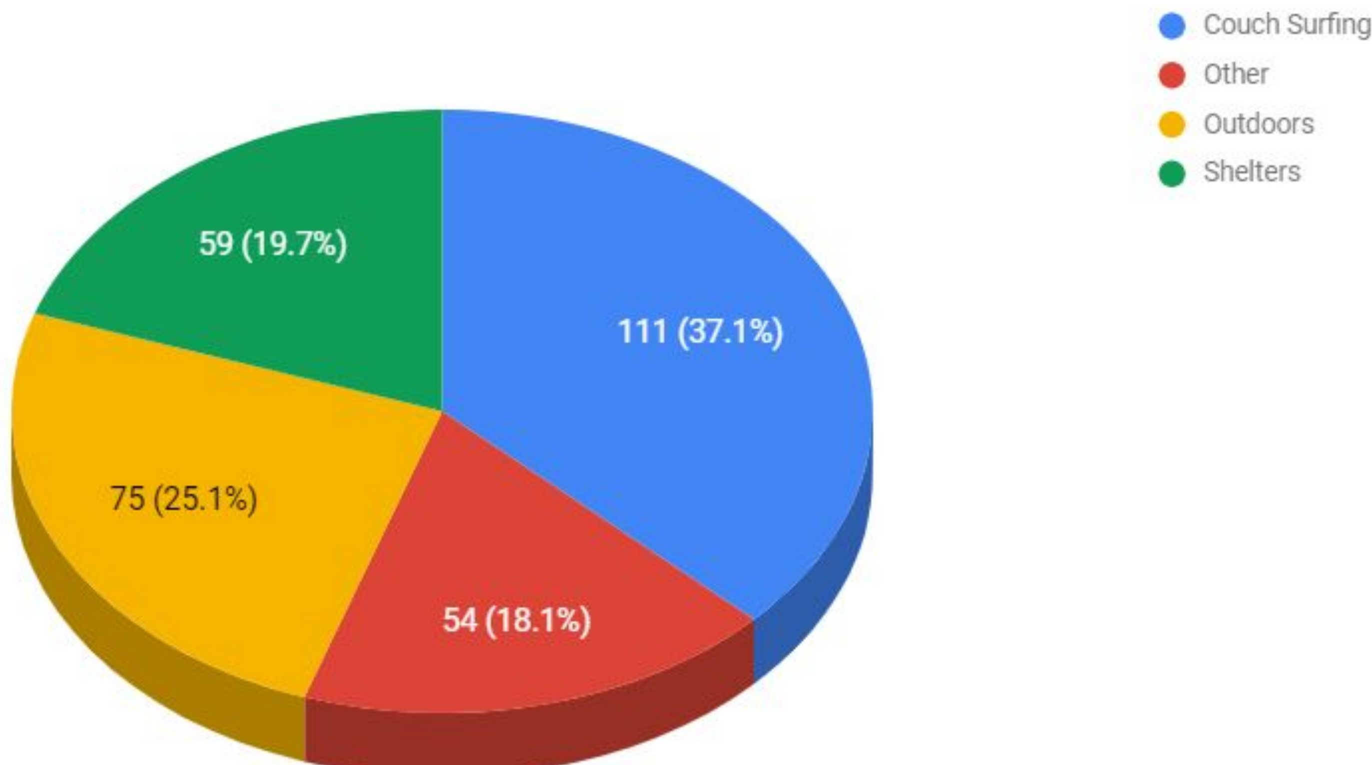
	Supported referrals	RRH (HM & E4C)
CSU costs	$ 84,735.07	$ 92,321
# people (duplicates removed)	69	55
CSU costs / # people	$ 1,228	$1,846

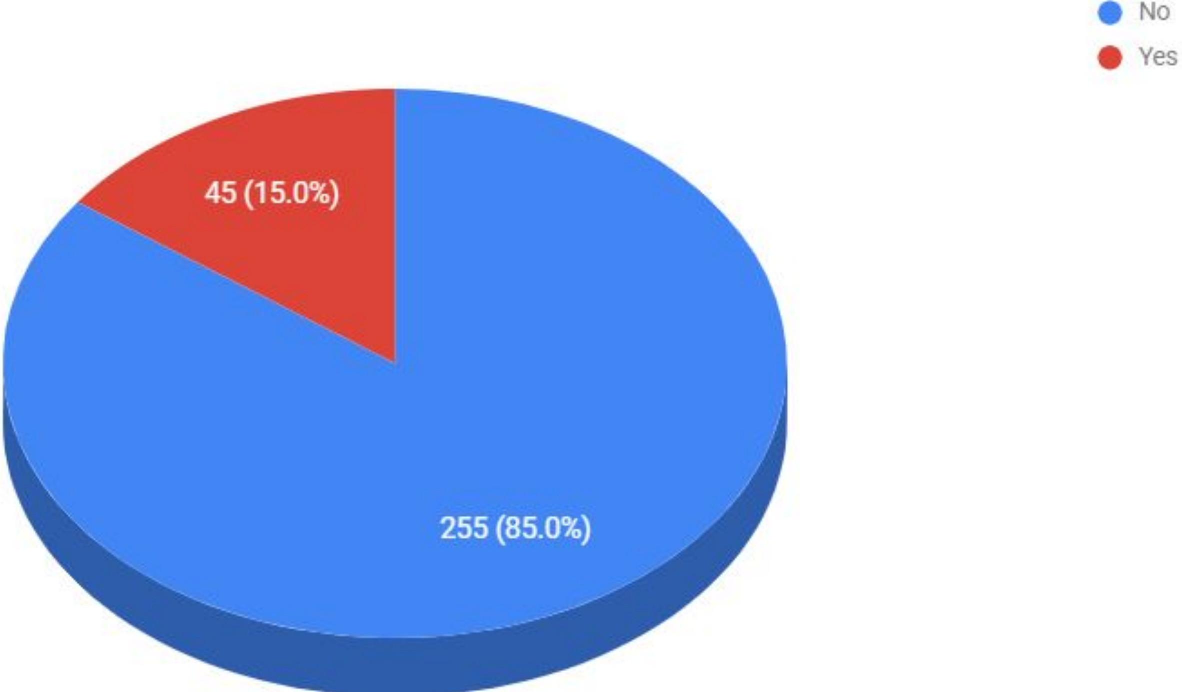
Data Notes

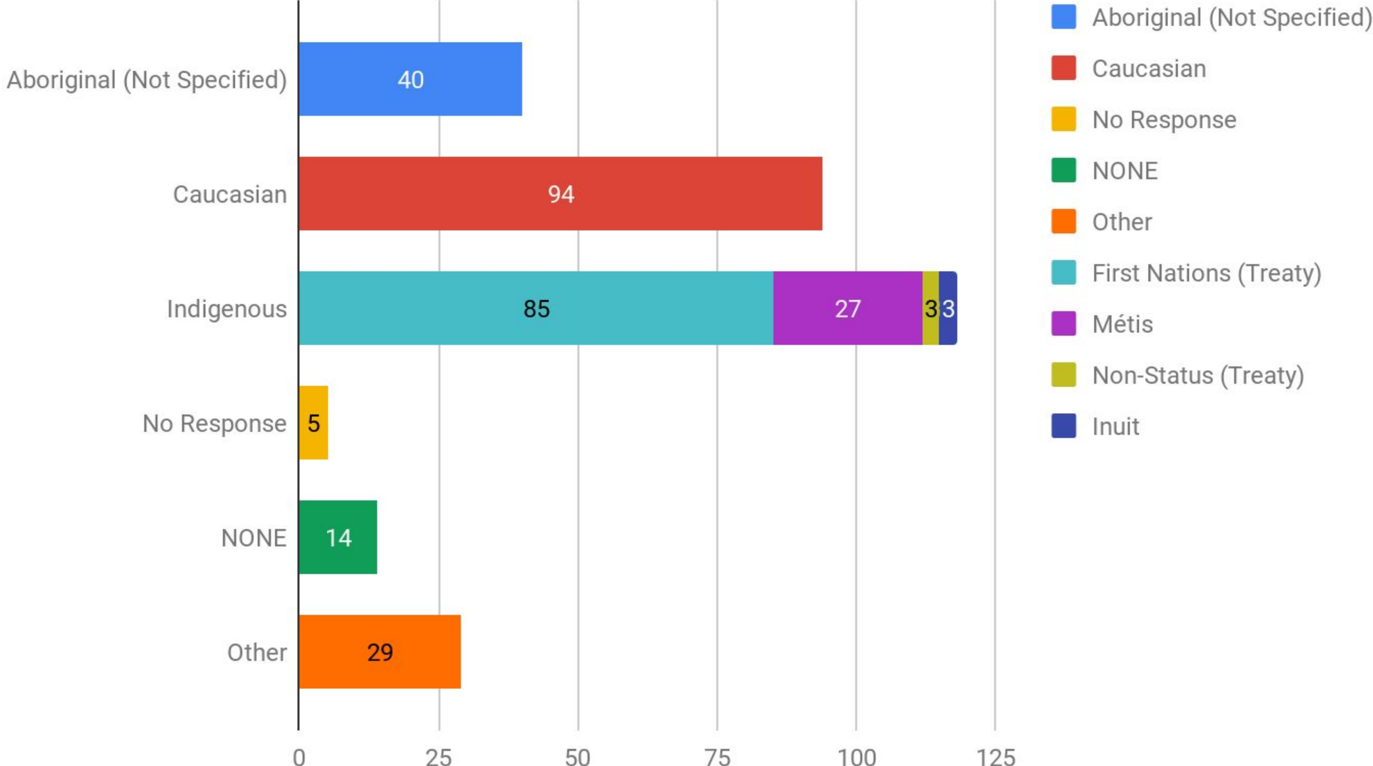
1)# people for SR declared in 'Supported Referrals to Dec17.xlsx', sheet '#s Housed': 69
2)# people for SR calculated in 'Supported Referral Analysis May 2018', sheet 'Supported Referral tracker': 55
3)# people for RRH calculated by HomeWard Trust & provided to evaluator in Excel sheet “CSU costs for RRH housings’

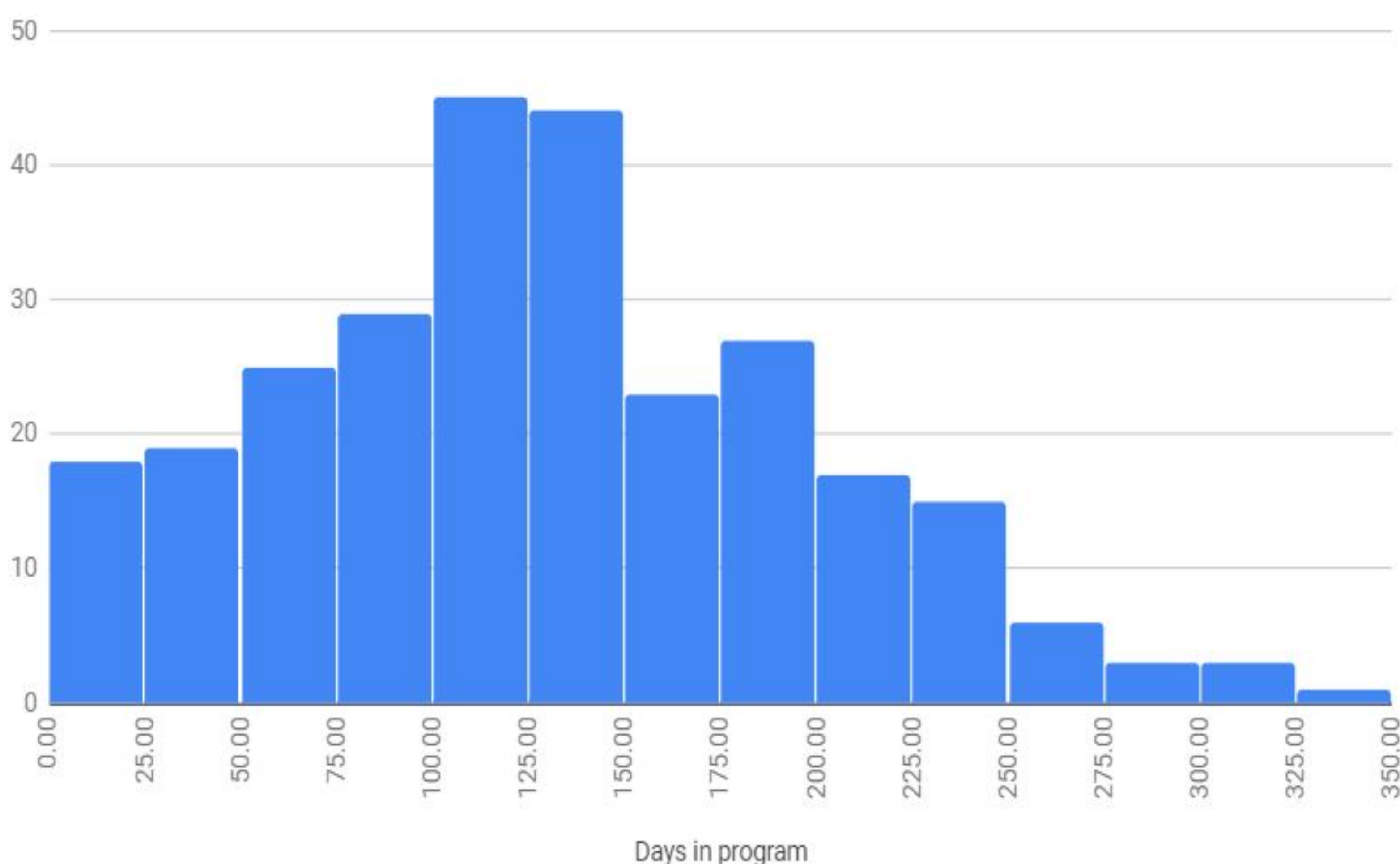
APPENDIX 1 - JOINED-UP DATASET ANALYSIS

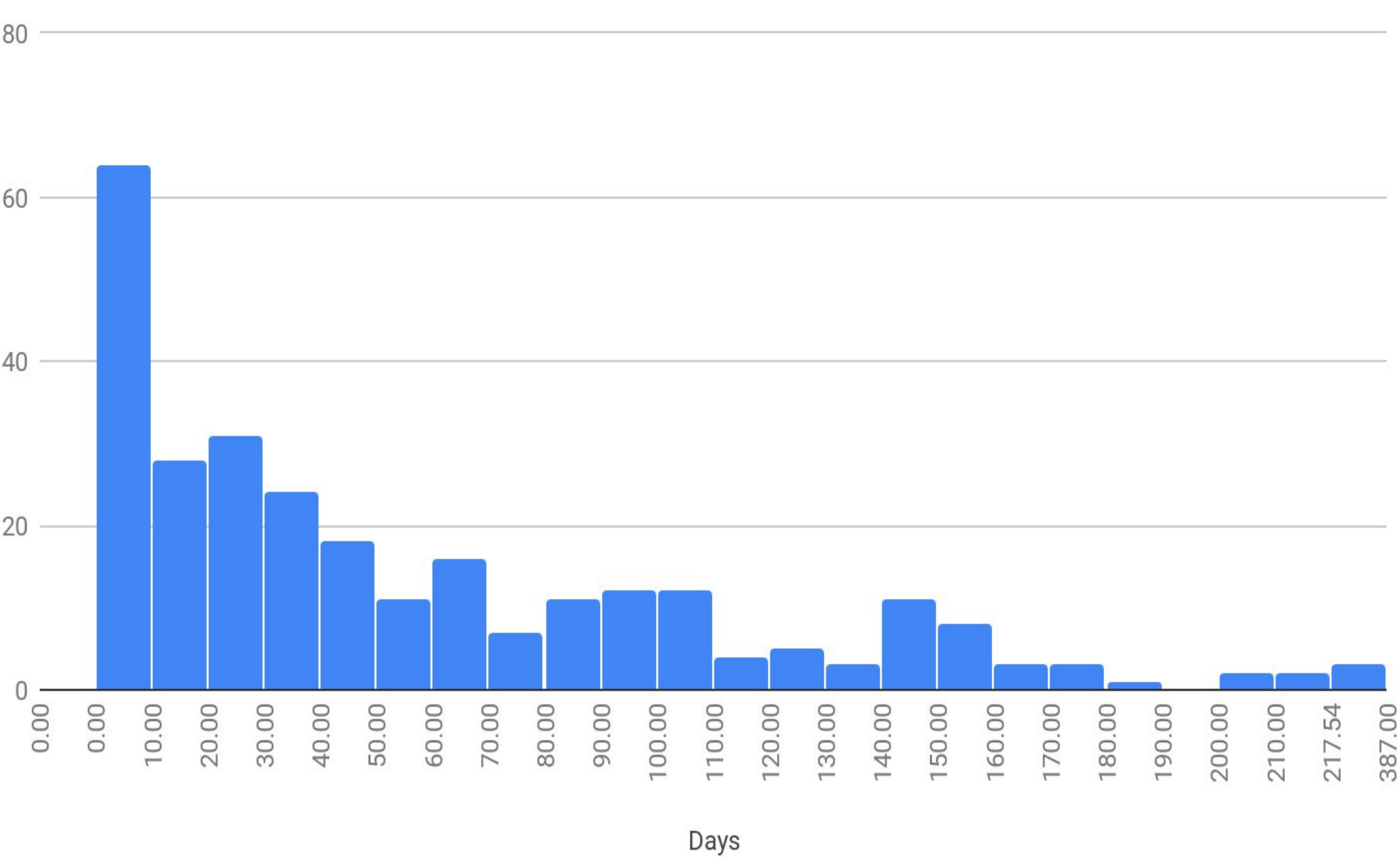


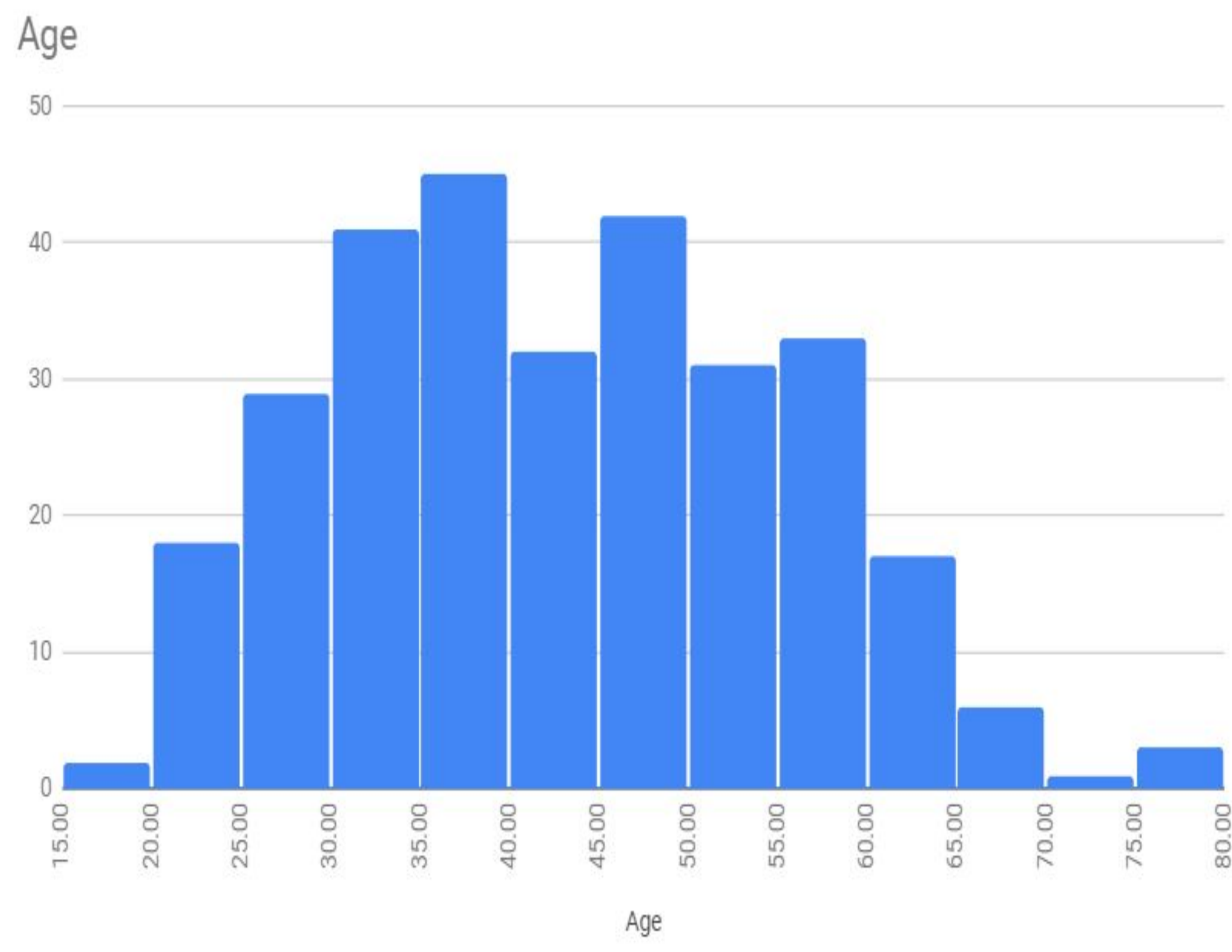




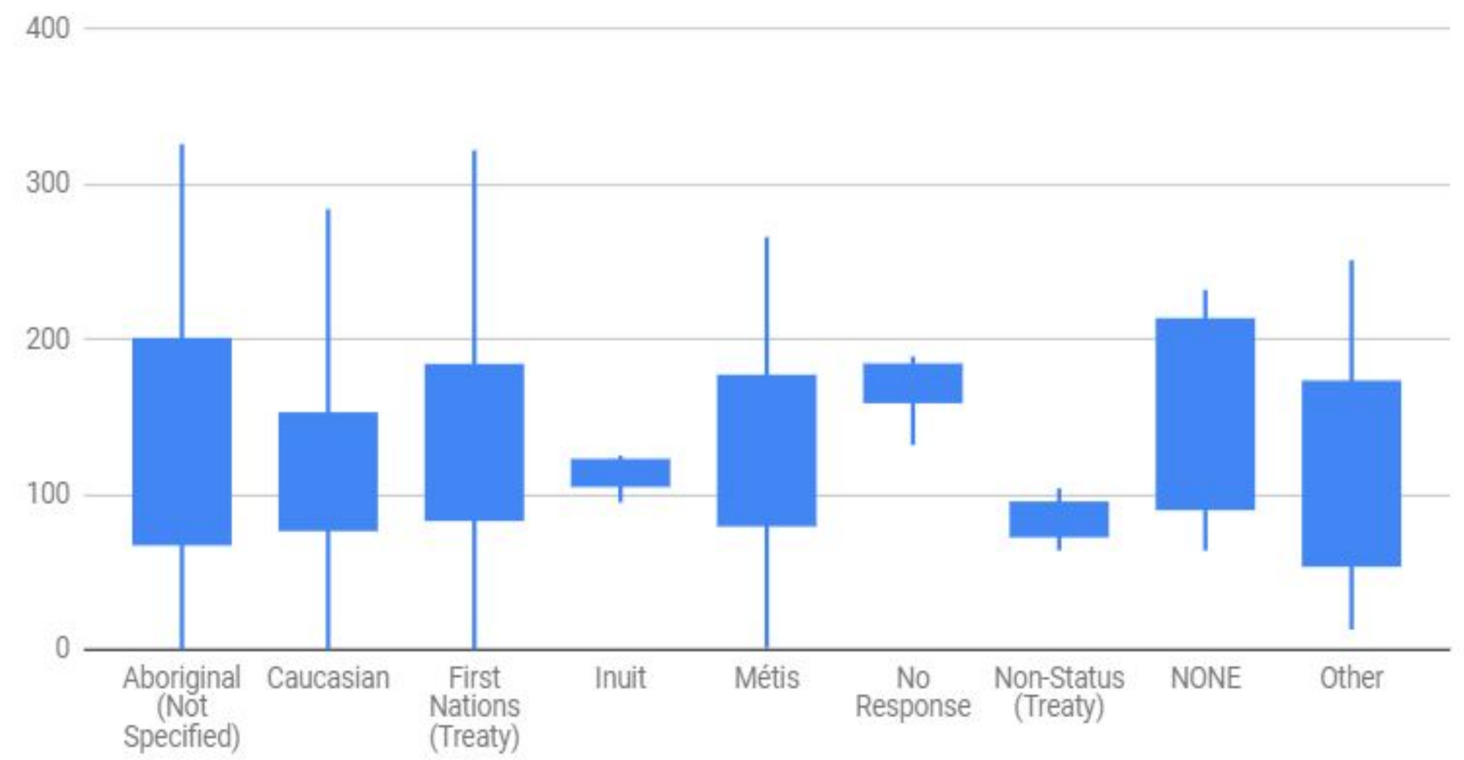




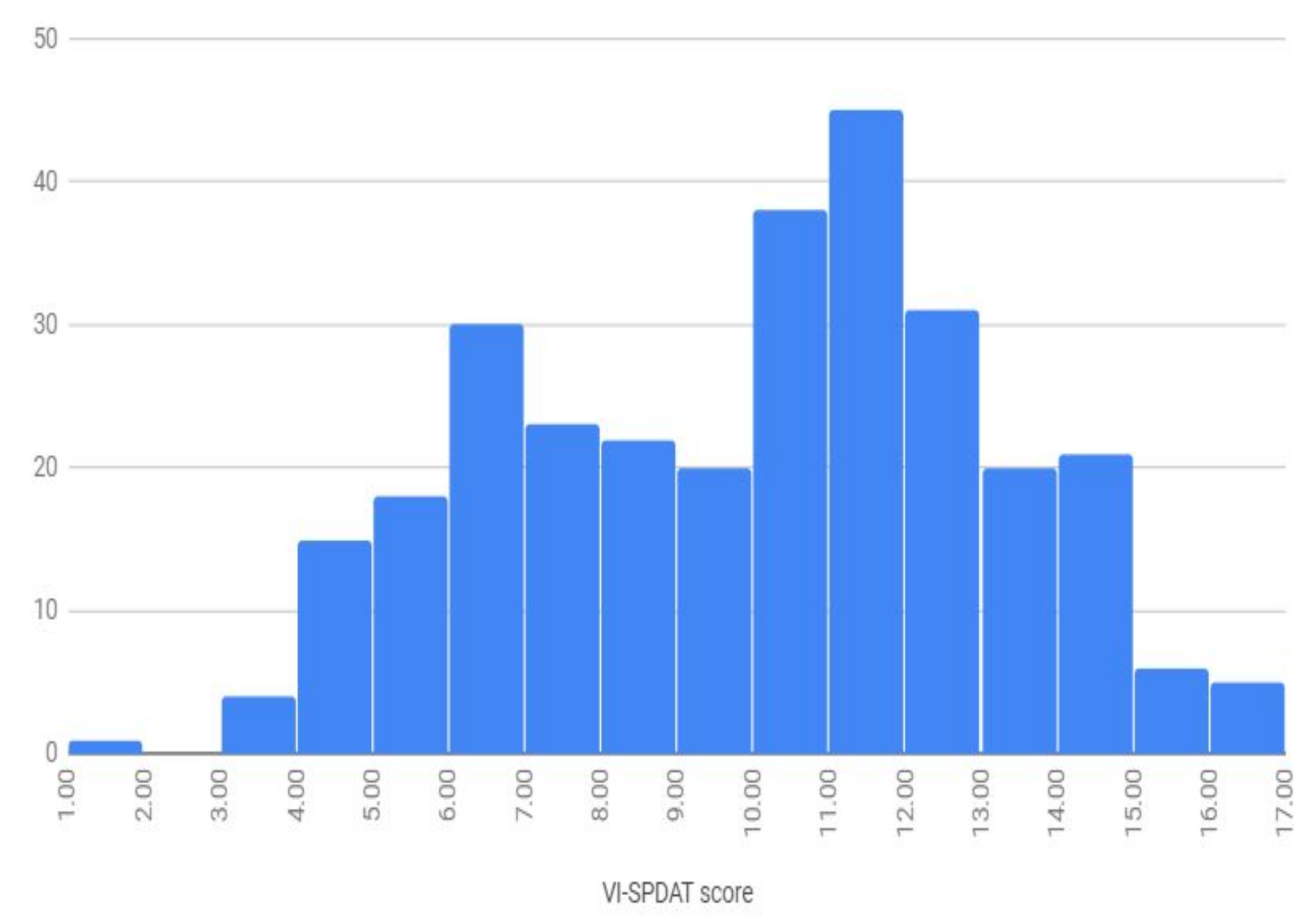




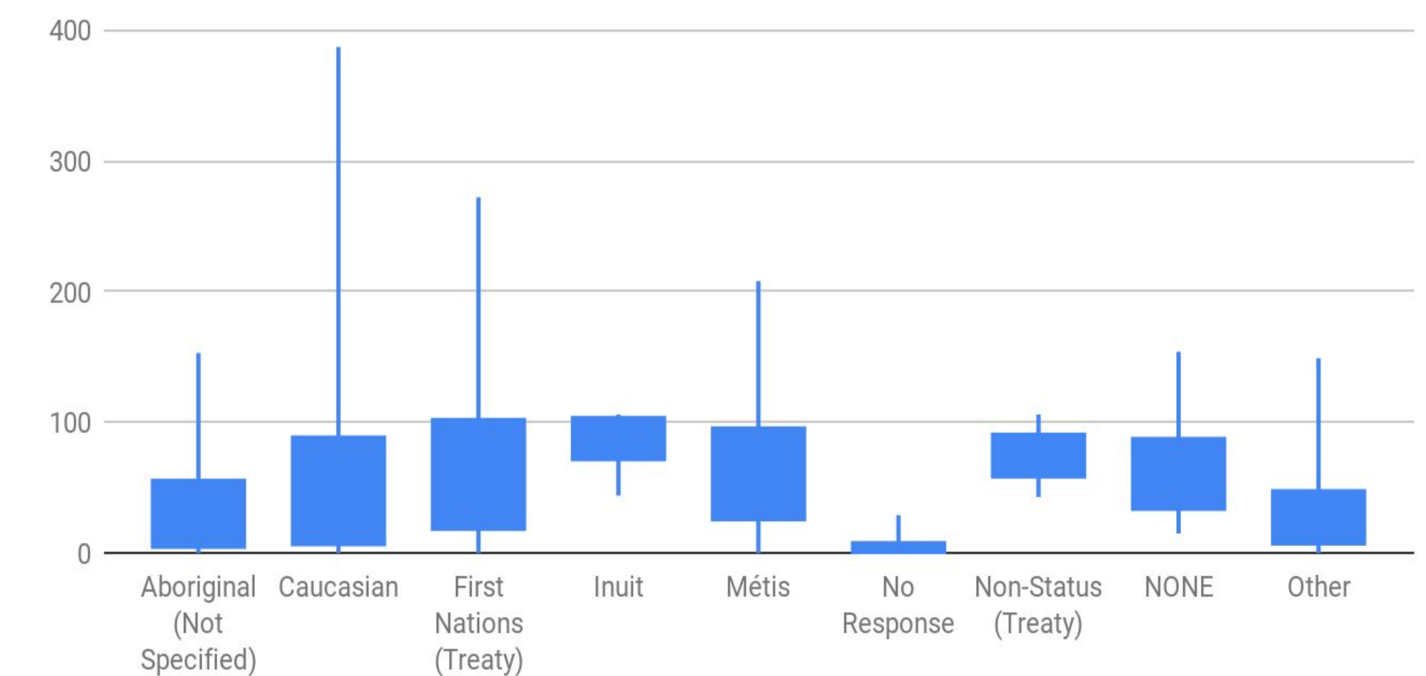
Age
50
40
30
20
10
0
15.00
20.00
25.00
30.00
35.00
40.00
45.00
50.00
55.00
60.00
65.00
70.00
75.00
80.00
Age



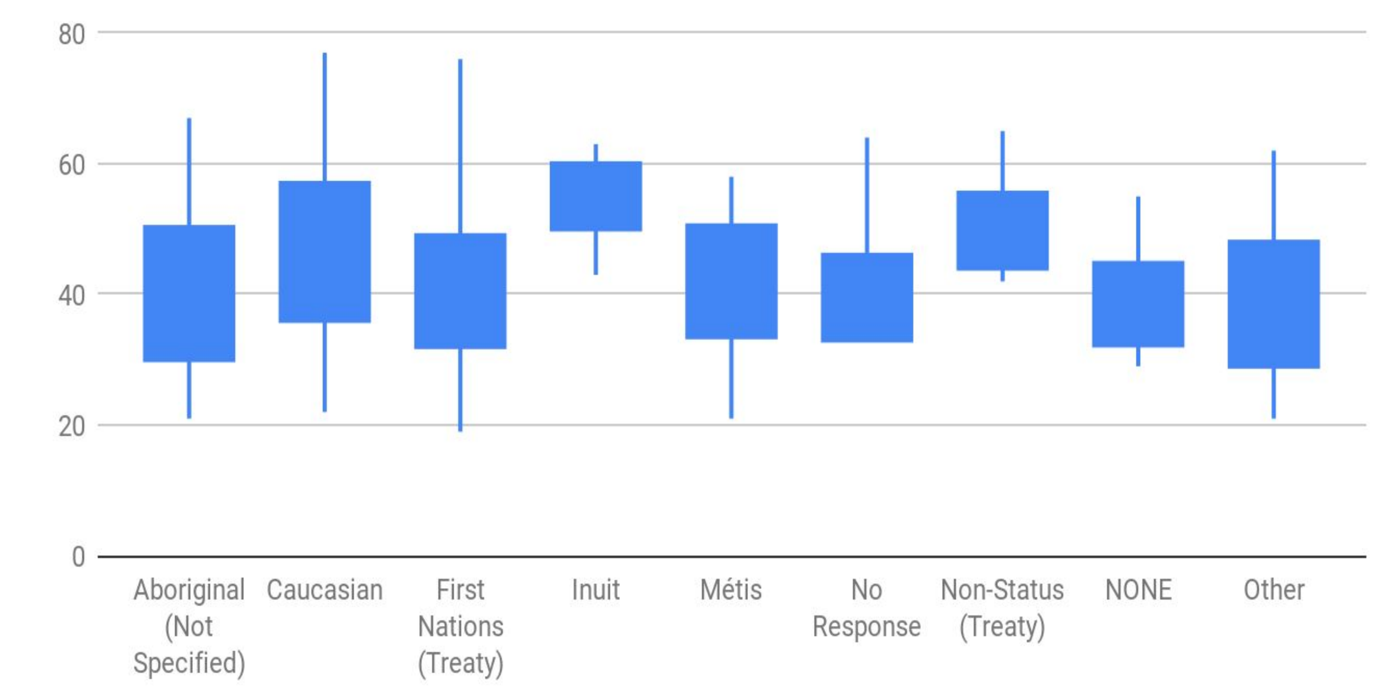
Days in program vs Ethnicity
400
300
200
100
0
Aboriginal (Not Specified)
Caucasian
First Nations (Treaty)
Inuit
Métis
No Response
Non-Status (Treaty)
NONE
Other



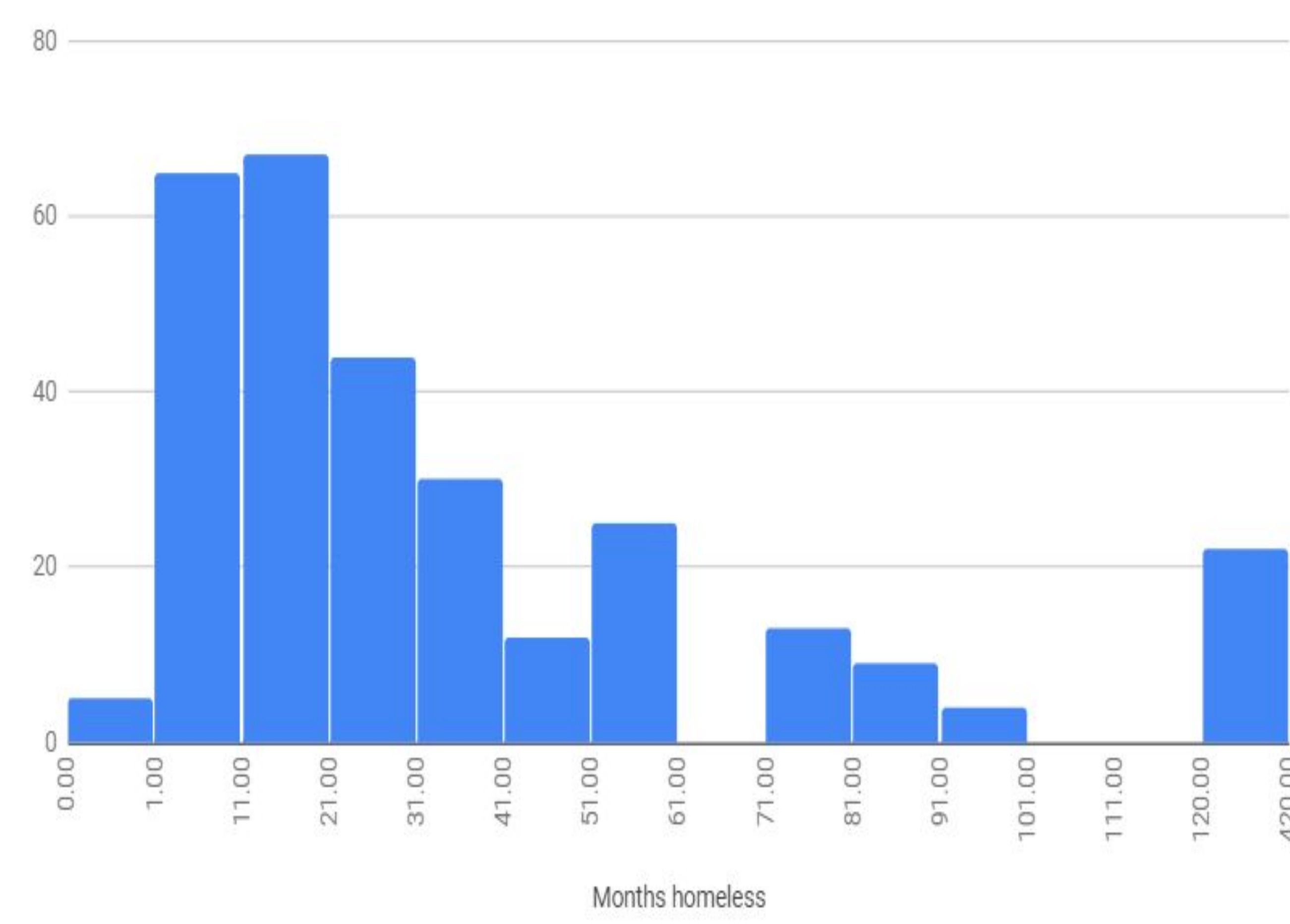
VI-SPDAT score
50
40
30
20
10
0
1.00
2.00
3.00
4.00
5.00
6.00
7.00
8.00
9.00
10.00
11.00
12.00
13.00
14.00
15.00
16.00
17.00
VI-SPDAT score



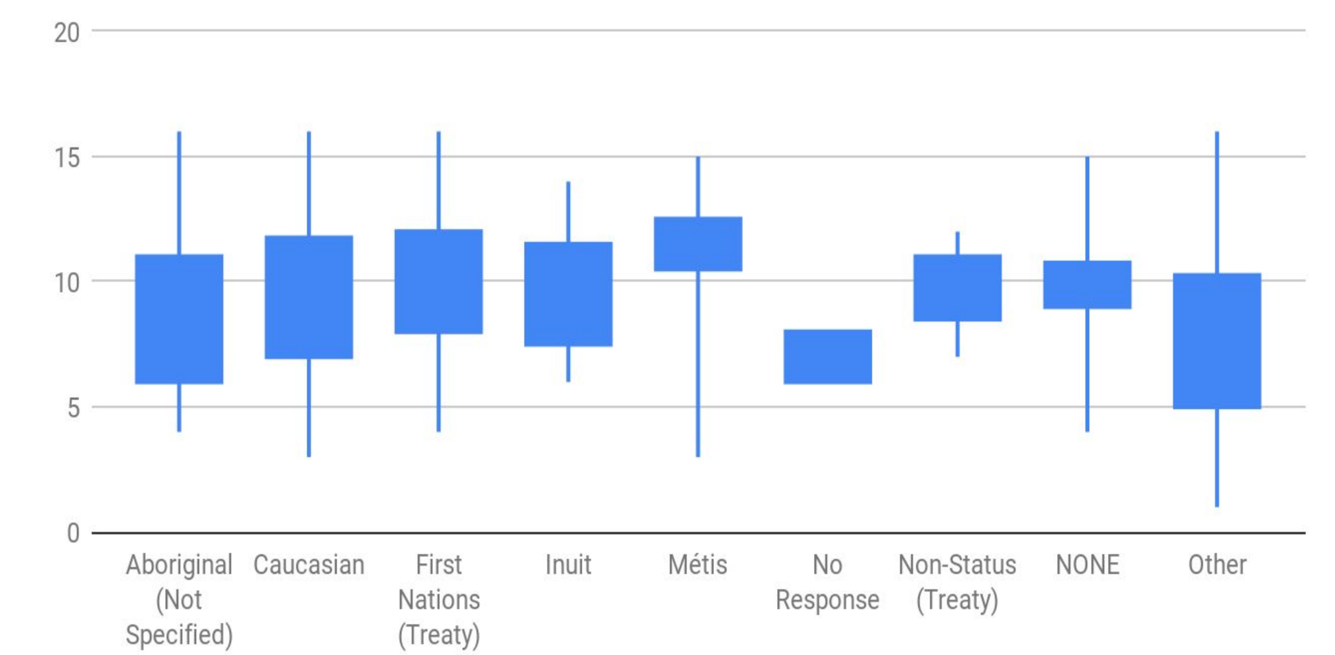
Time from Intake to Housing vs Ethnicity
400
300
200
100
0
Aboriginal (Not Specified)
Caucasian
First Nations (Treaty)
Inuit
Métis
No Response
Non-Status (Treaty)
NONE
Other



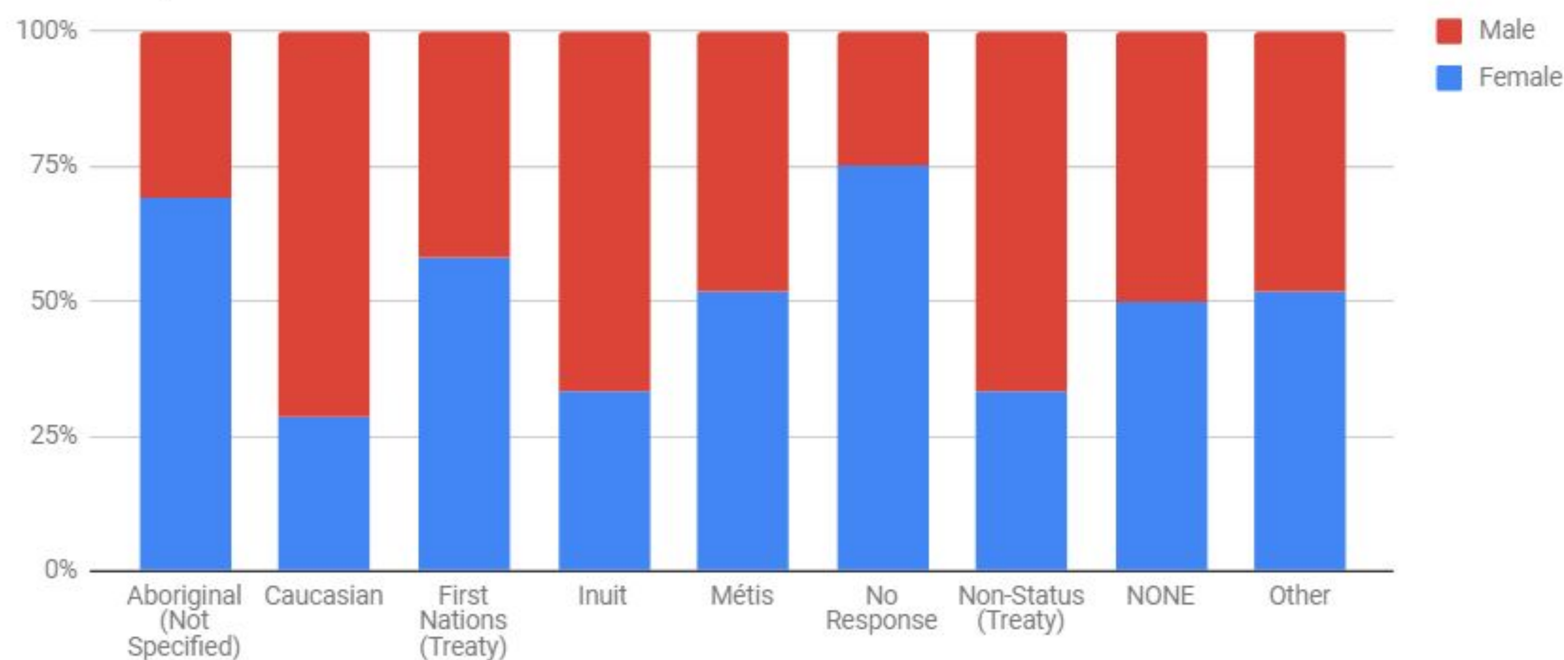
Age vs Ethnicity
80
60
40
20
0
Aboriginal (Not Specified)
Caucasian
First Nations (Treaty)
Inuit
Métis
No Response
Non-Status (Treaty)
NONE
Other



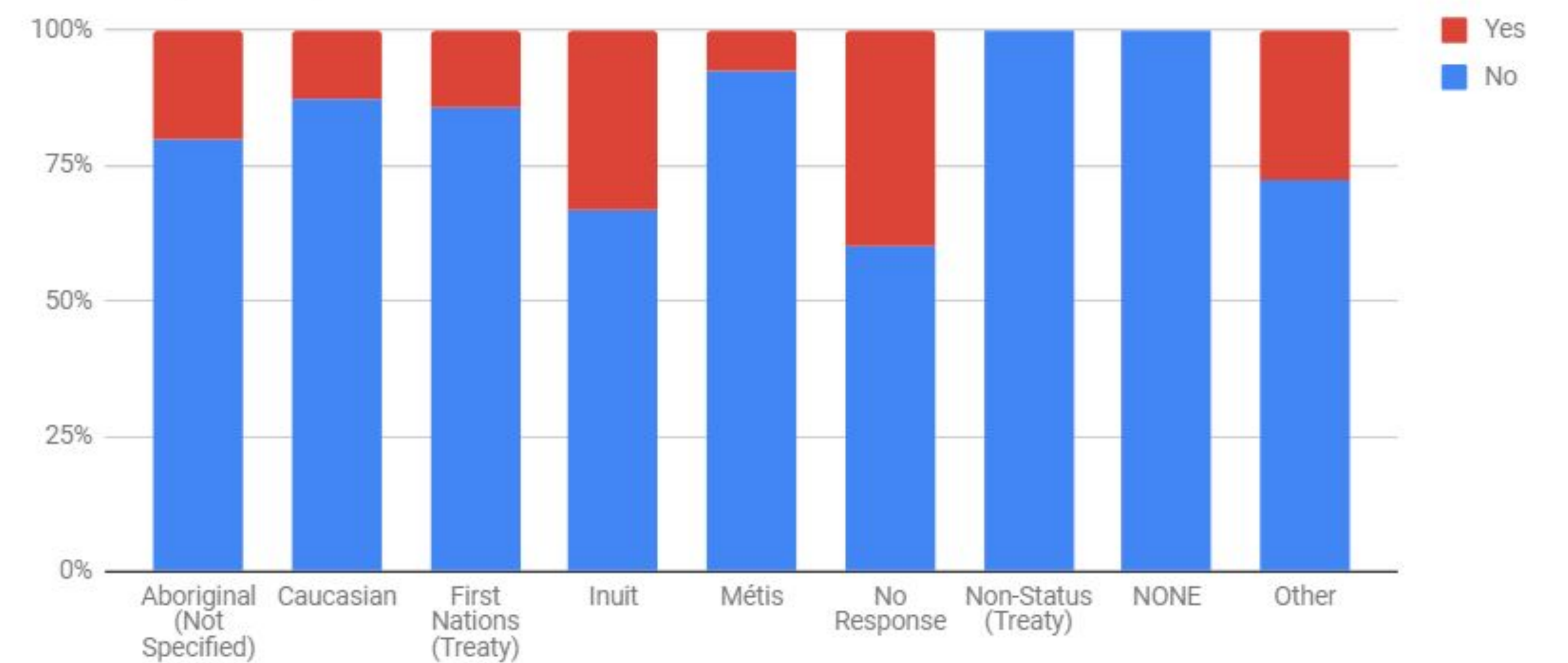
Months homeless
80
60
40
20
0
0.00
1.00
11.00
21.00
31.00
41.00
51.00
61.00
71.00
81.00
91.00
101.00
111.00
120.00
420.00
Months homeless



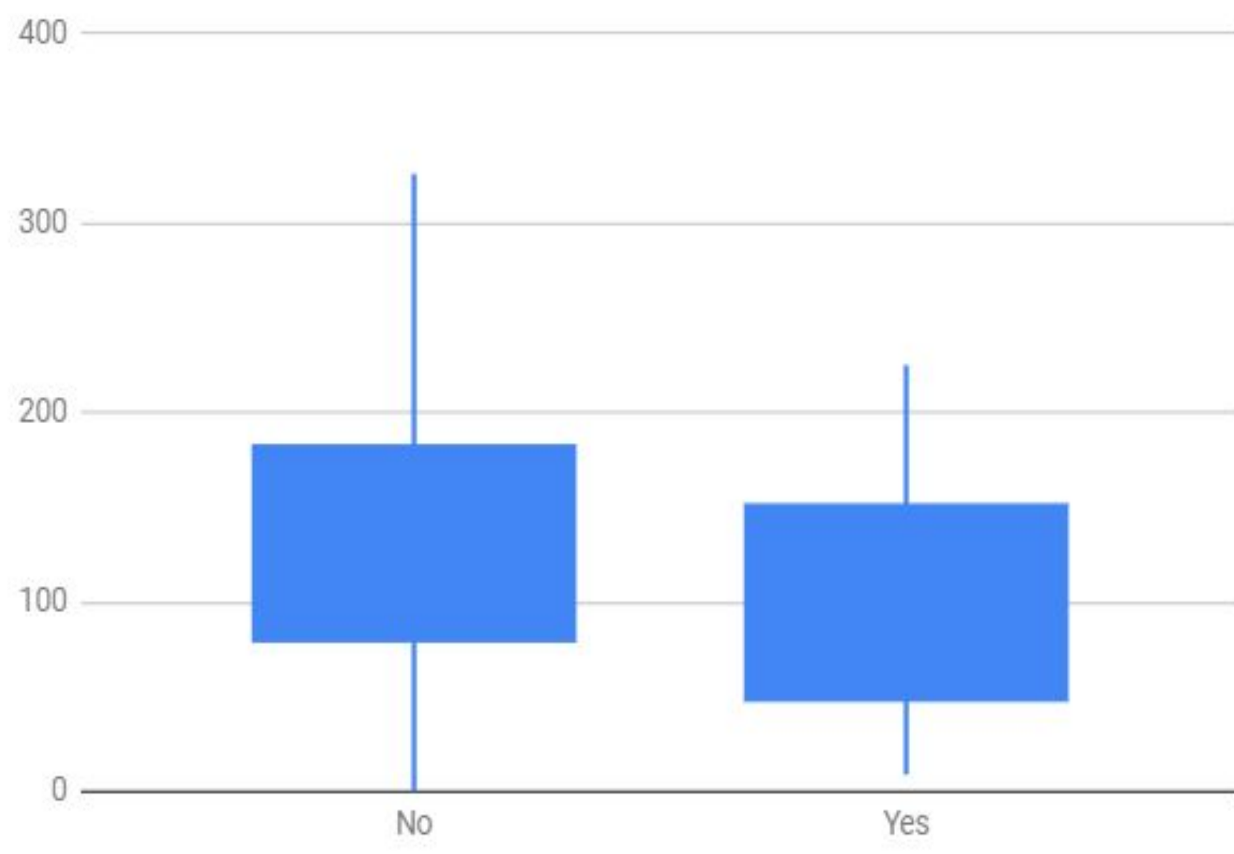
VI-SPDAT score vs Ethnicity
20
15
10
5
0
Aboriginal (Not Specified)
Caucasian
First Nations (Treaty)
Inuit
Métis
No Response
Non-Status (Treaty)
NONE
Other

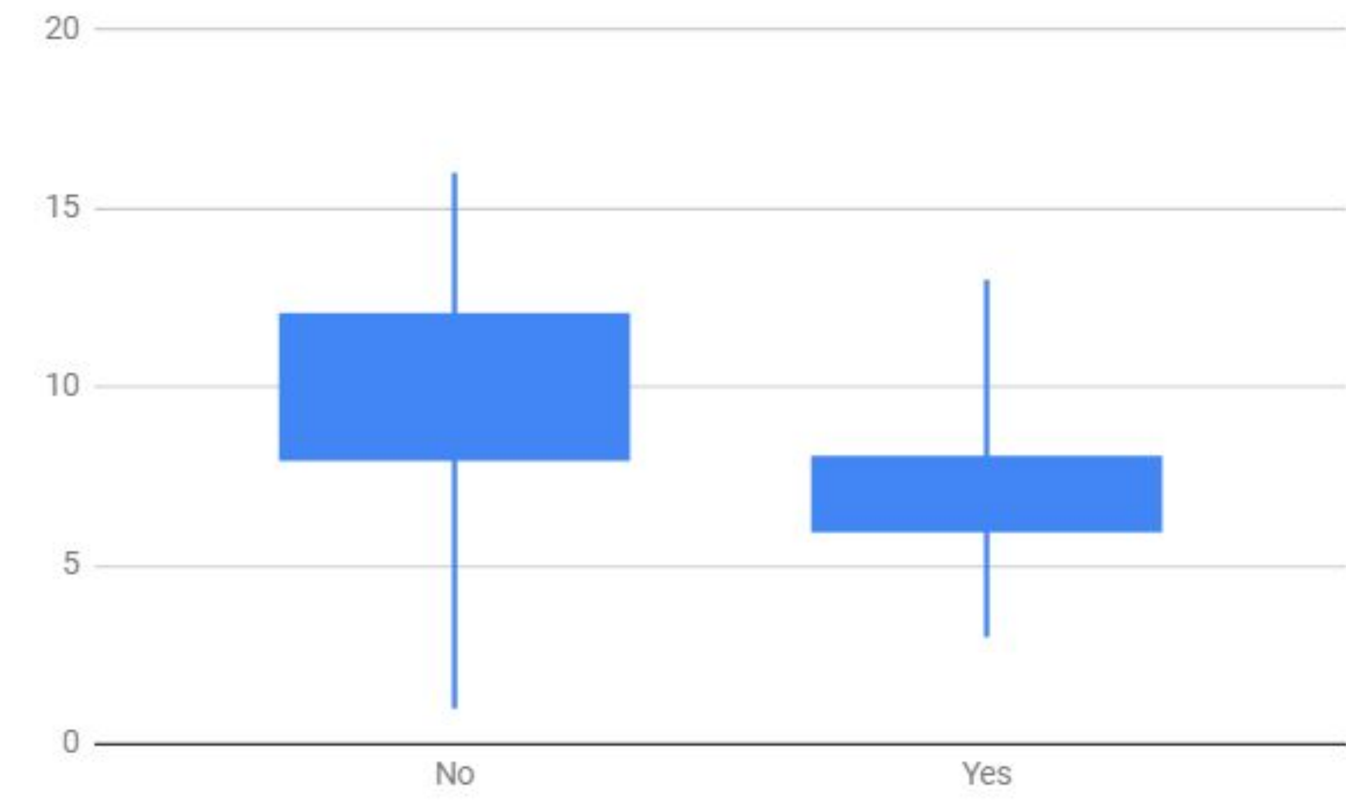


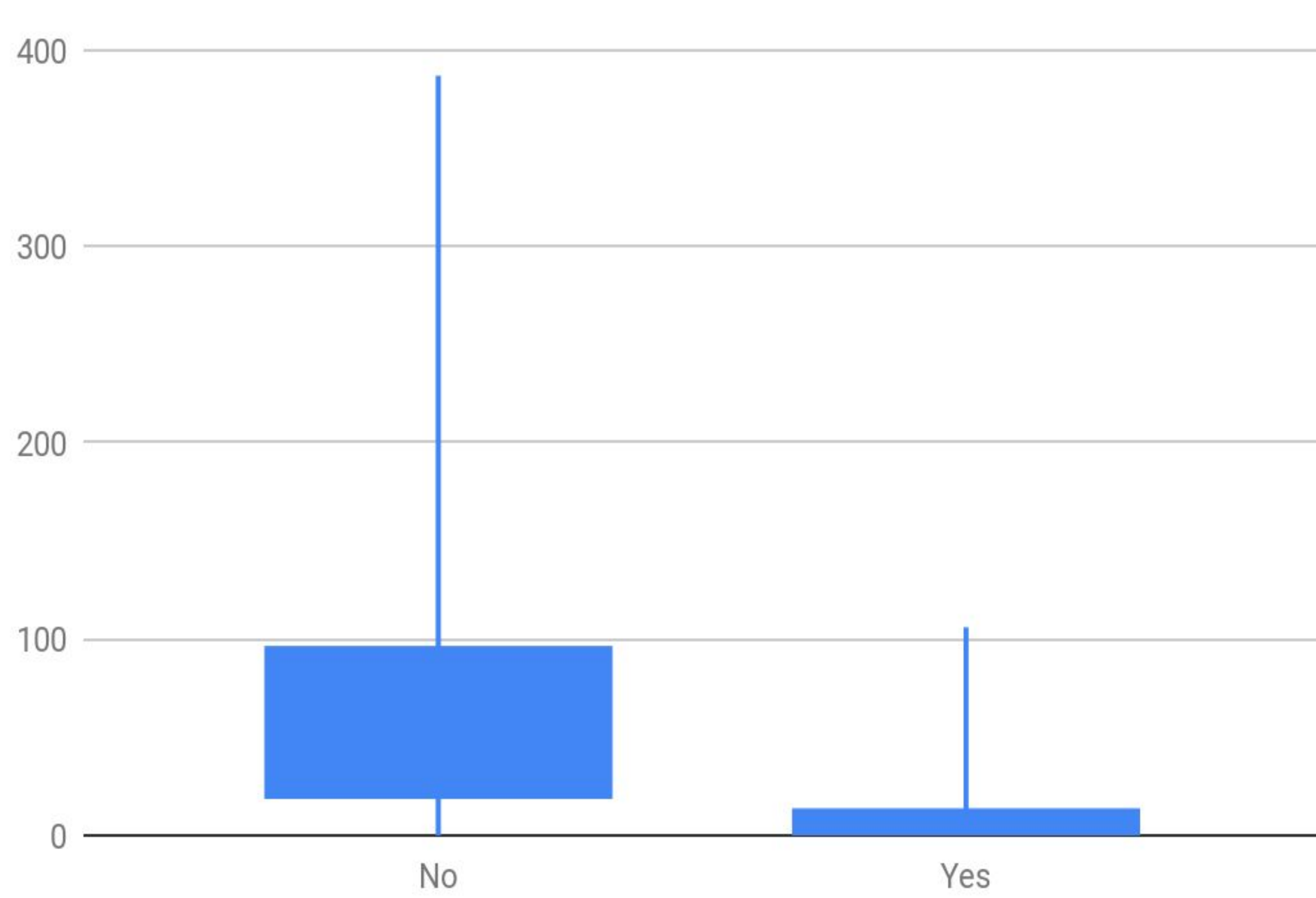
Ethnicity vs Gender
100%
75%
50%
25%
0%
Male
Female
Aboriginal (Not Specified)
Caucasian
First Nations (Treaty)
Inuit
Métis
No Response
Non-Status (Treaty)
NONE
Other

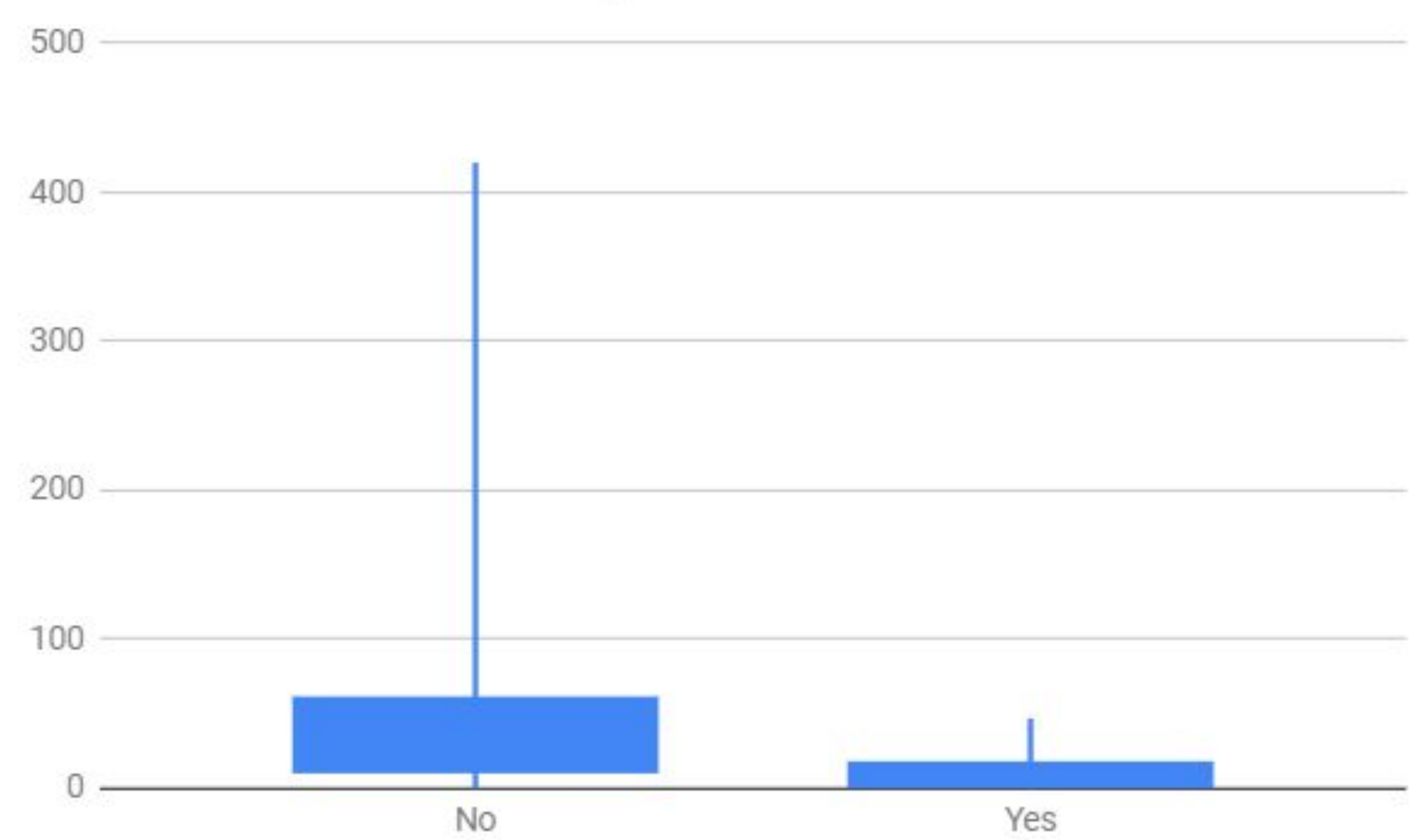


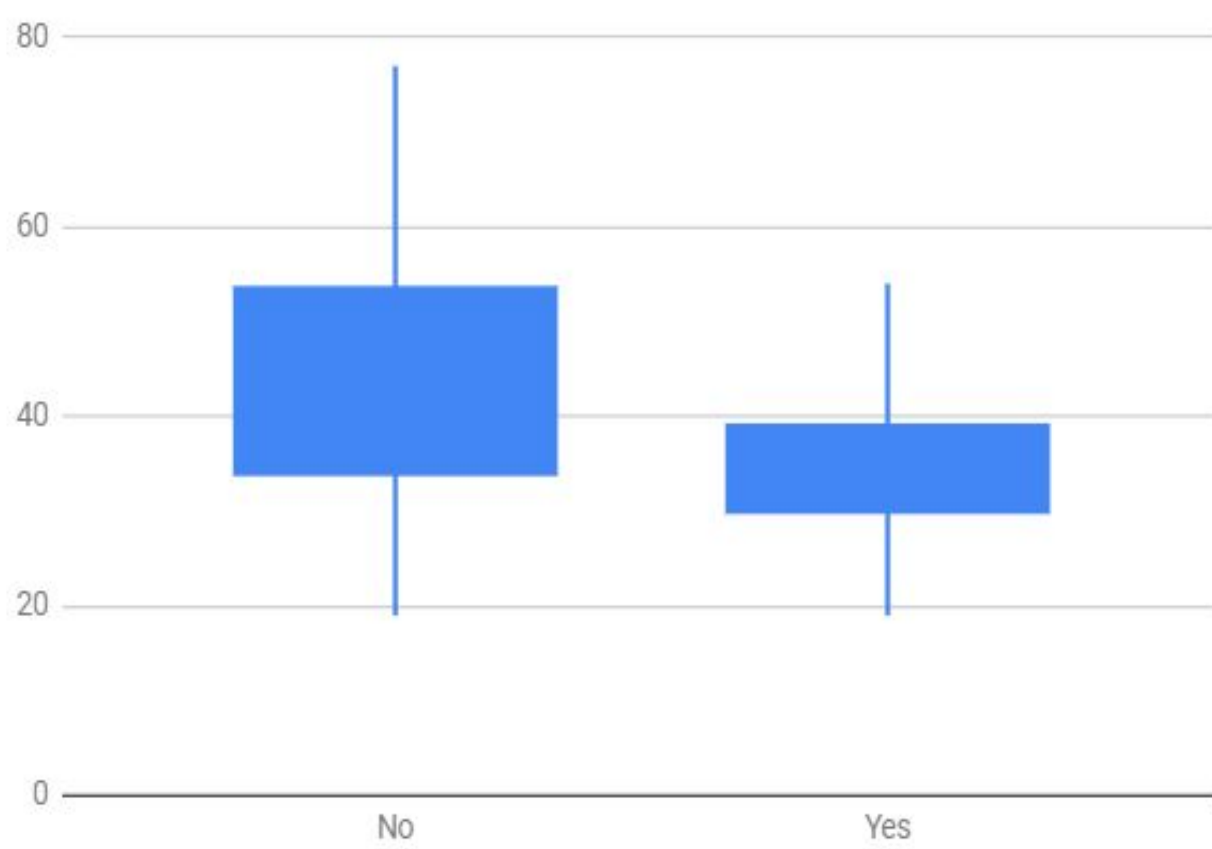
Ethnicity vs Dependent
100%
75%
50%
25%
0%
Yes
No
Aboriginal (Not Specified)
Caucasian
First Nations (Treaty)
Inuit
Métis
No Response
Non-Status (Treaty)
NONE
Other

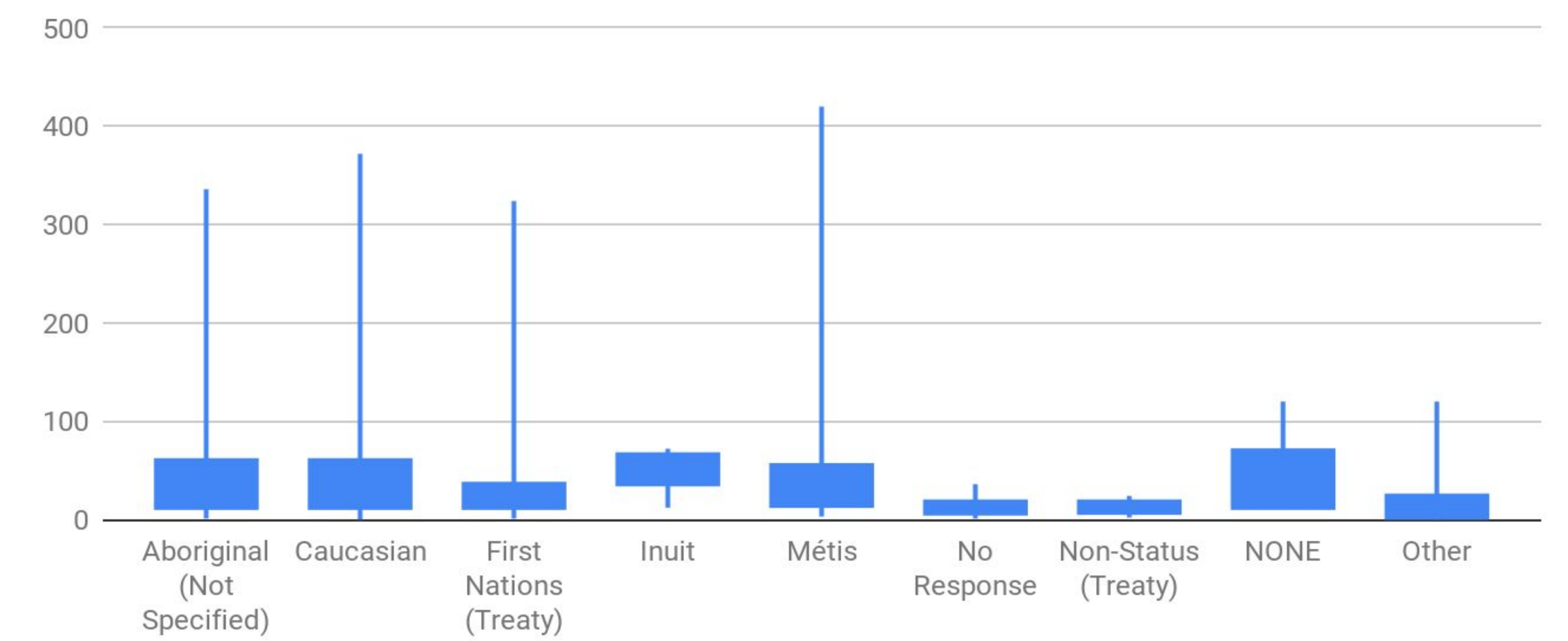

Days in program vs Dependent
400
300
200
100
0
No
Yes

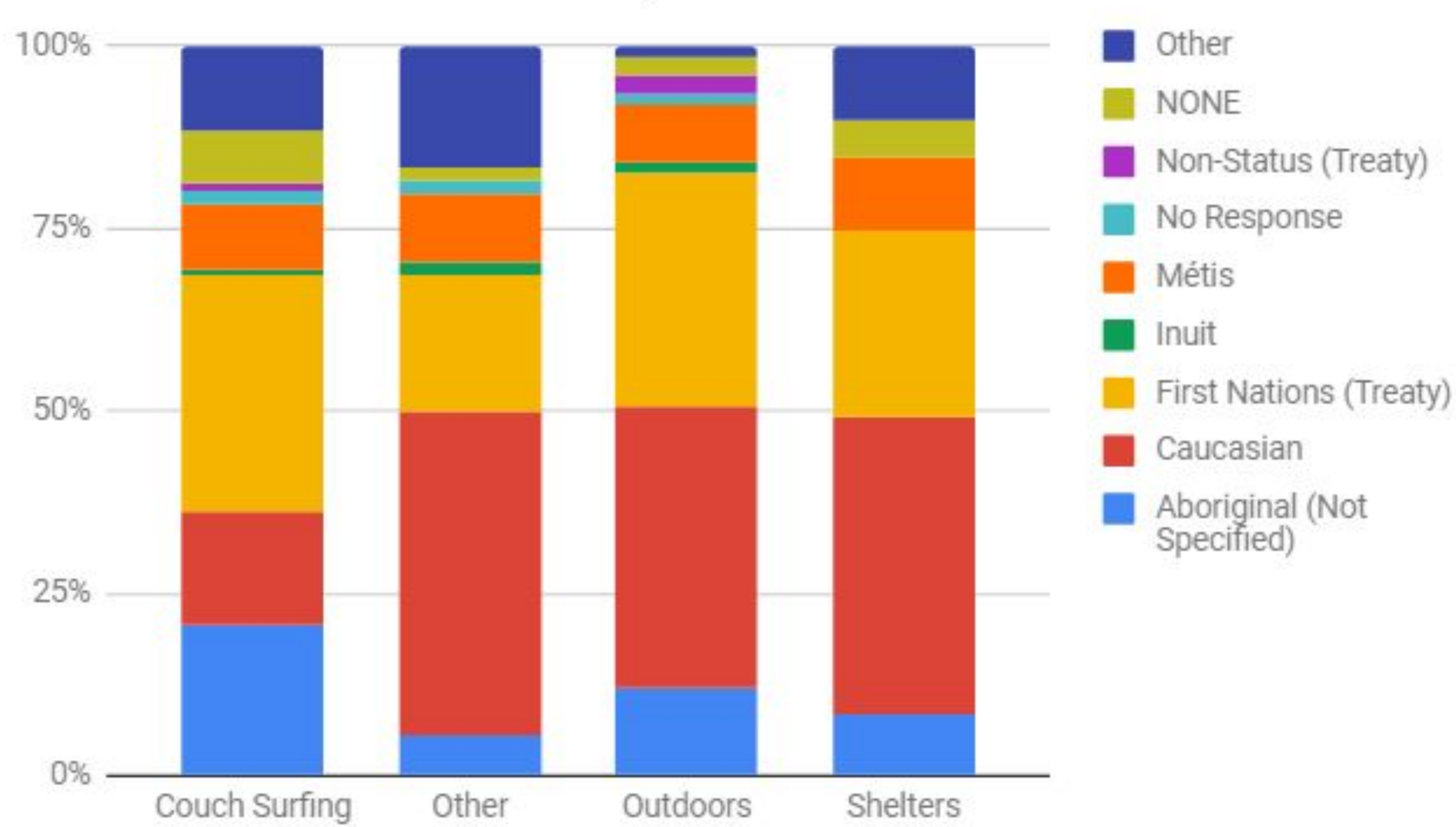

VI-SPDAT score vs Dependent
20
15
10
5
0
No
Yes

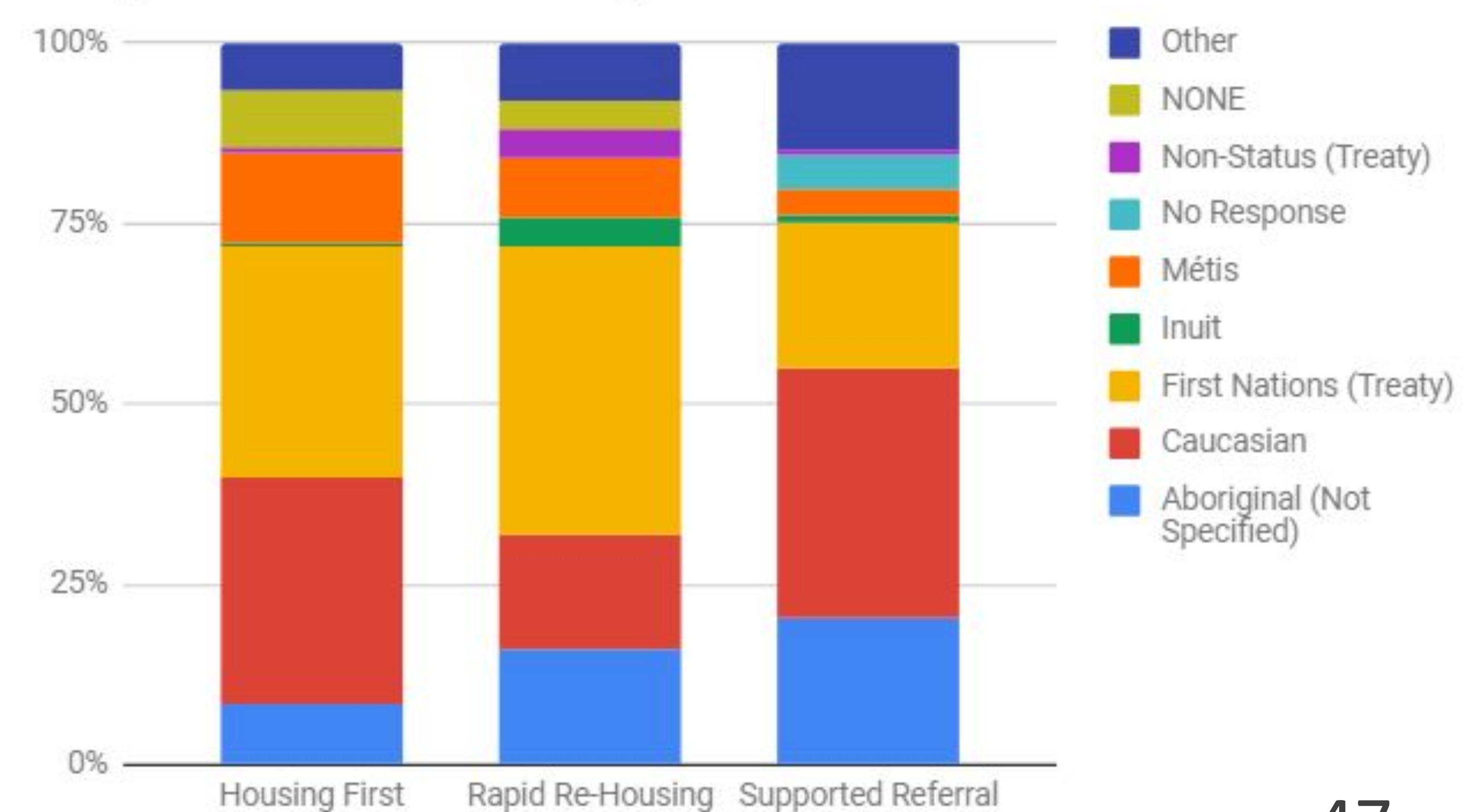

Time from Intake to Housing vs Dependent
400
300
200
100
0
No
Yes

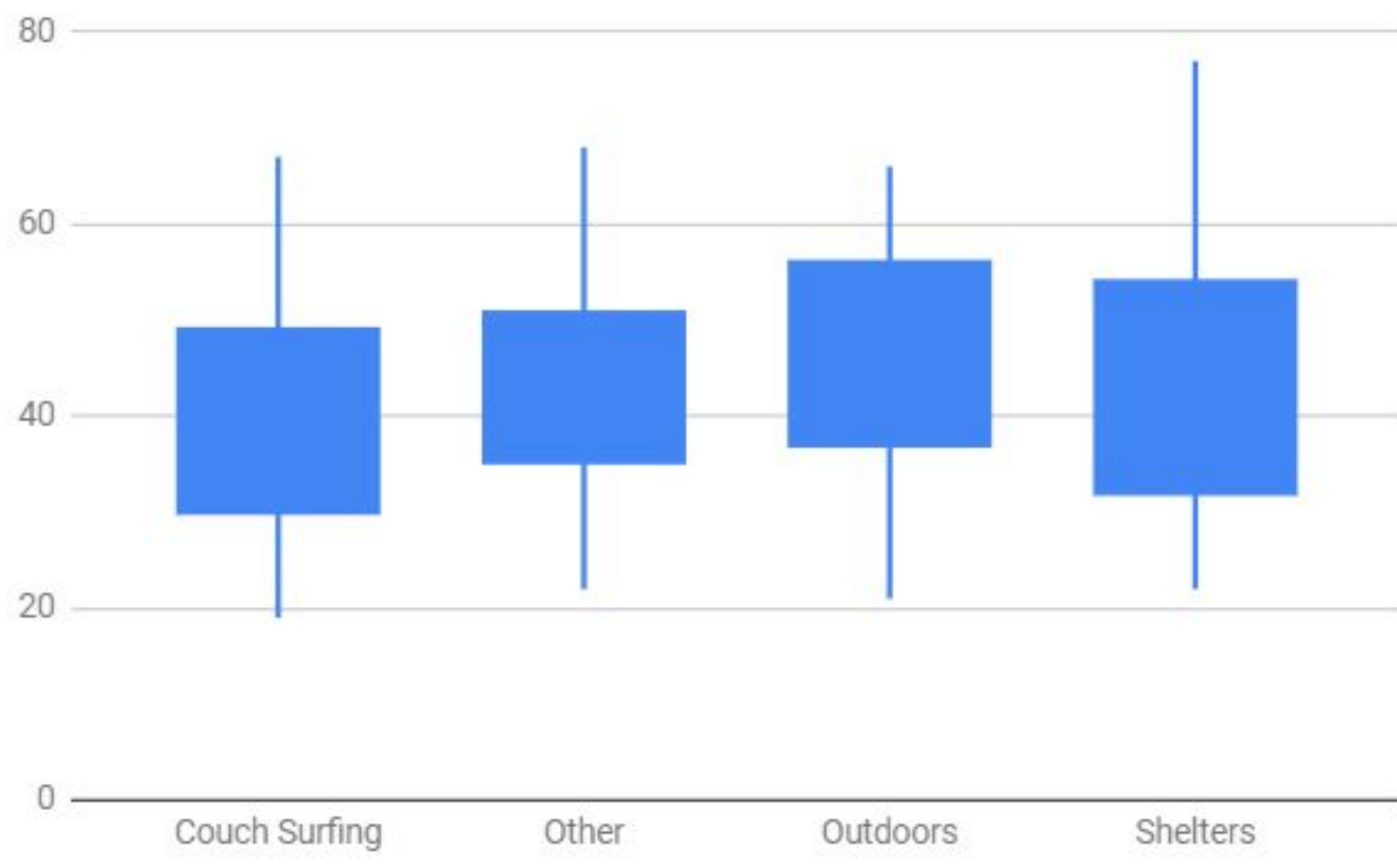

Months homeless vs Dependent
500
400
300
200
100
0
No
Yes

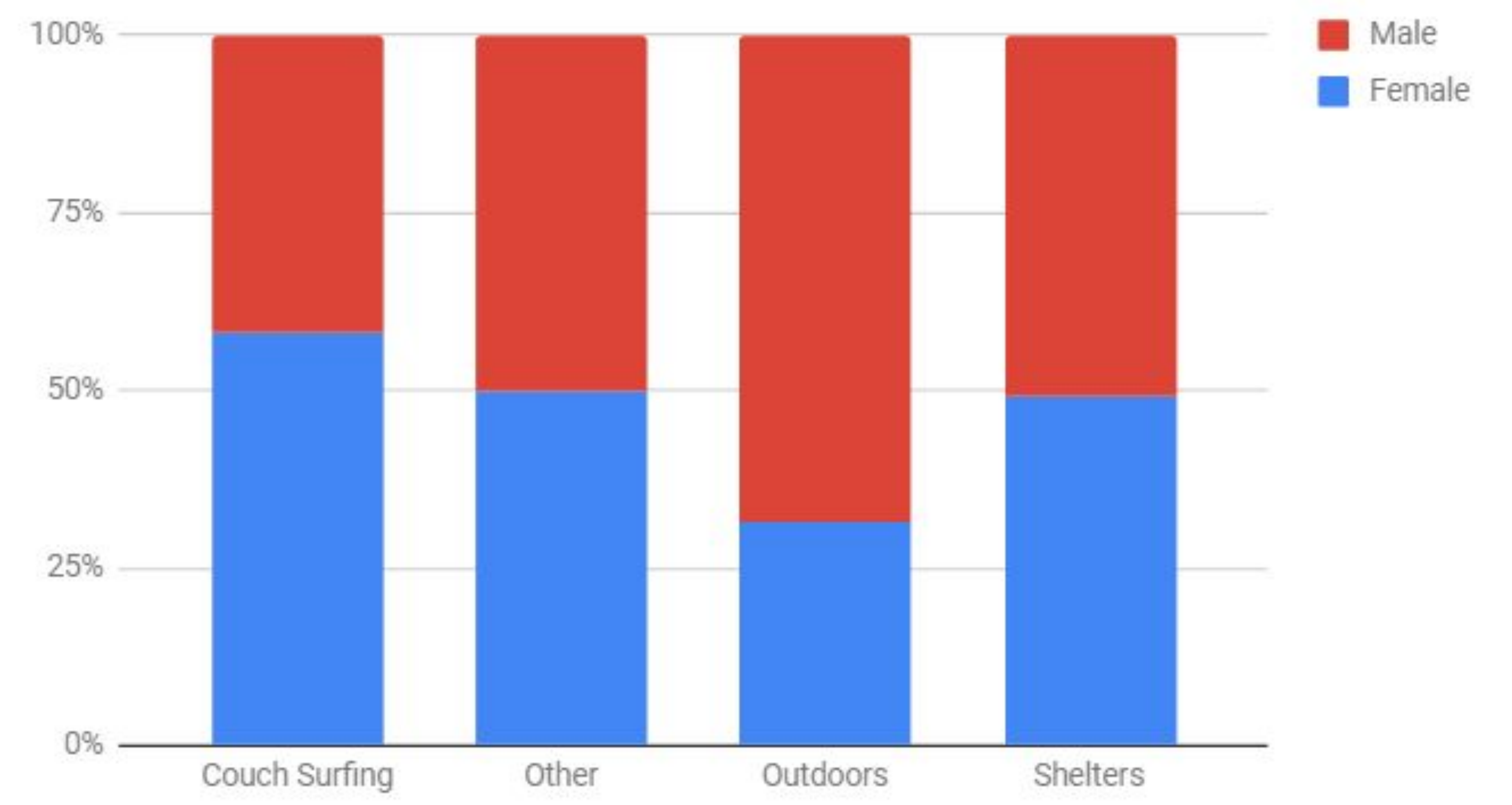

Age vs Dependent
80
60
40
20
0
No
Yes

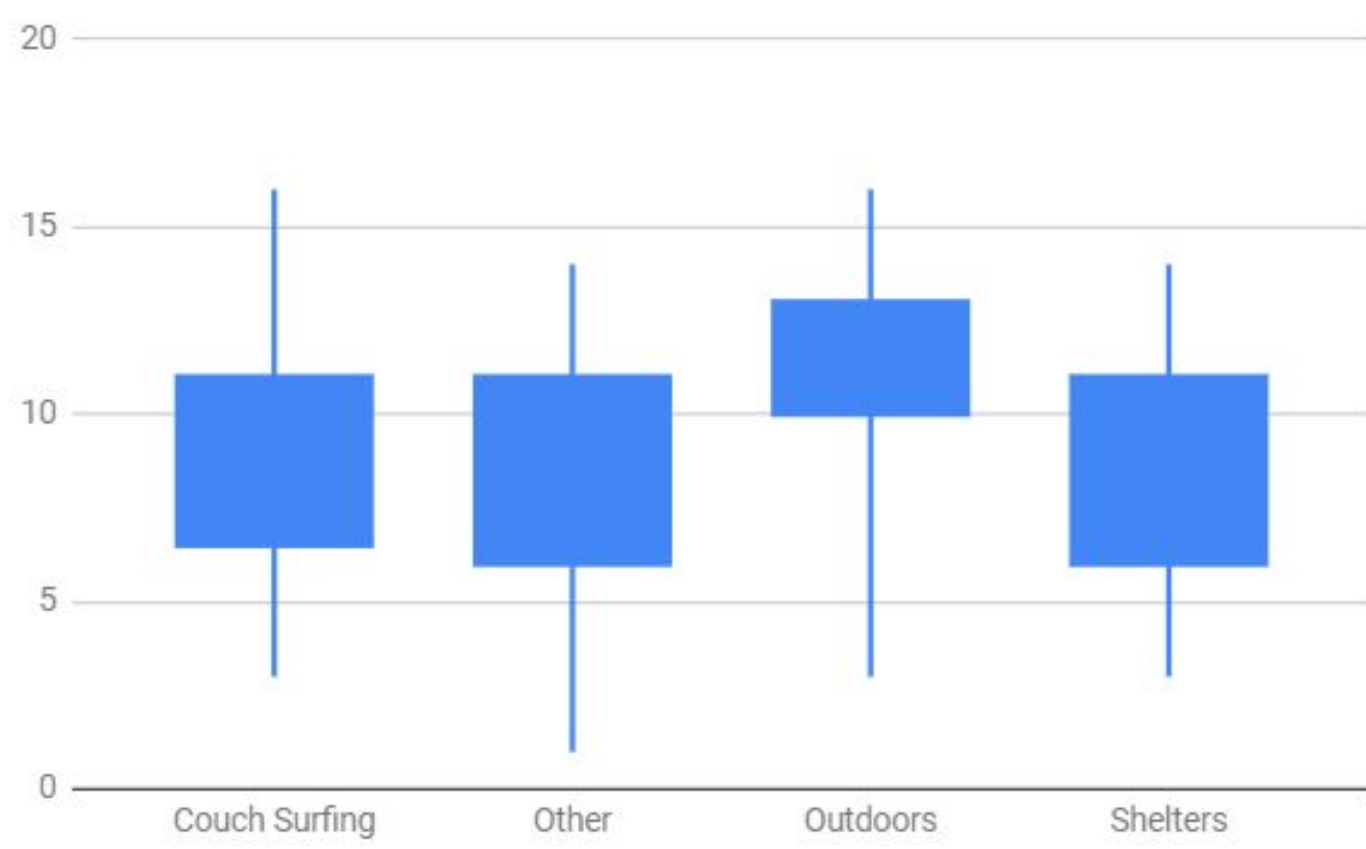

Months homeless vs Ethnicity
500
400
300
200
100
0
Aboriginal (Not Specified)
Caucasian
First Nations (Treaty)
Inuit
Métis
No Response
Non-Status (Treaty)
NONE
Other

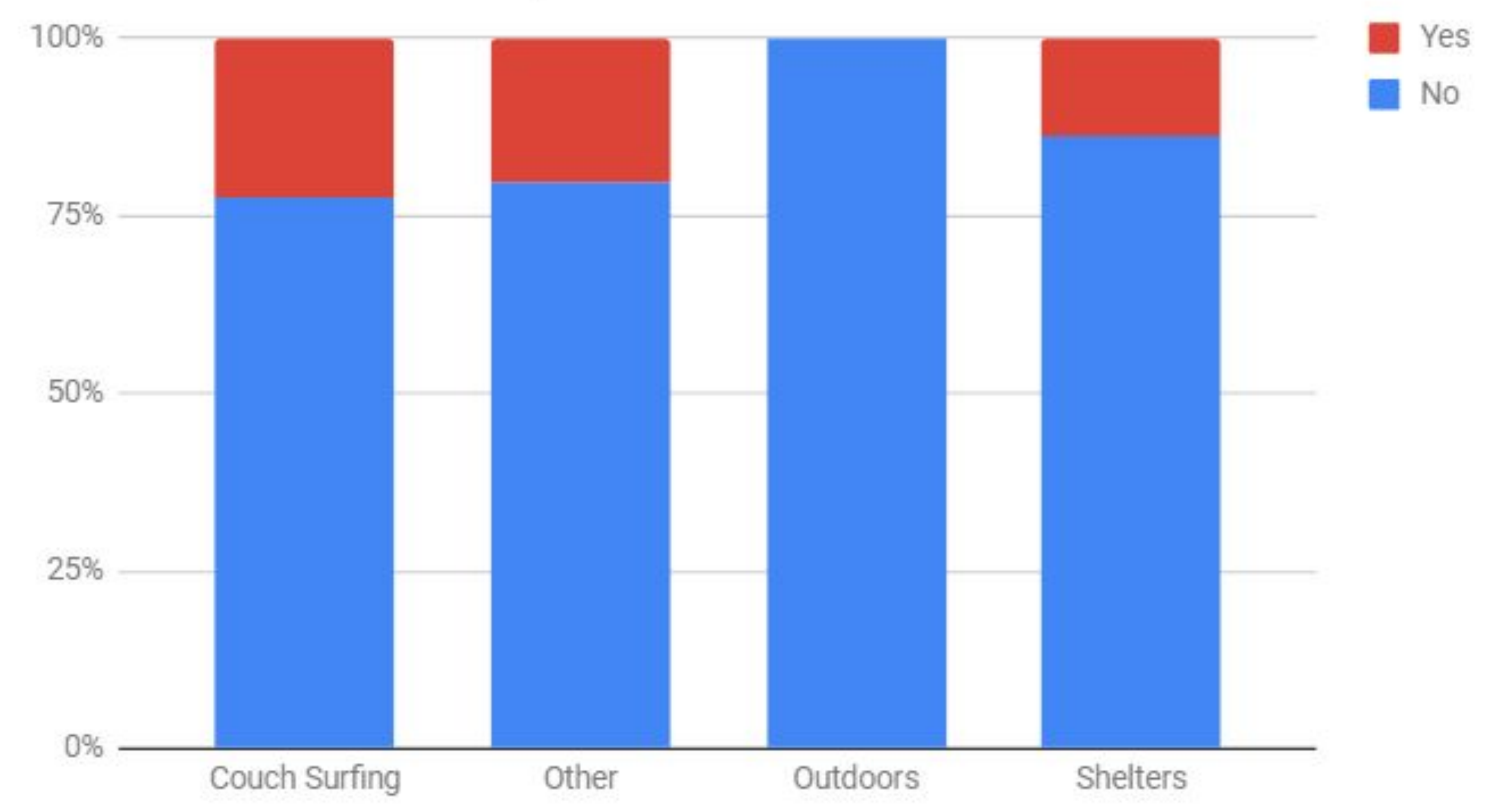

Current location vs Ethnicity
100%
75%
50%
25%
0%
Couch Surfing
Other
Outdoors
Shelters
Other
NONE
Non-Status (Treaty)
No Response
Métis
Inuit
First Nations (Treaty)
Caucasian
Aboriginal (Not Specified)

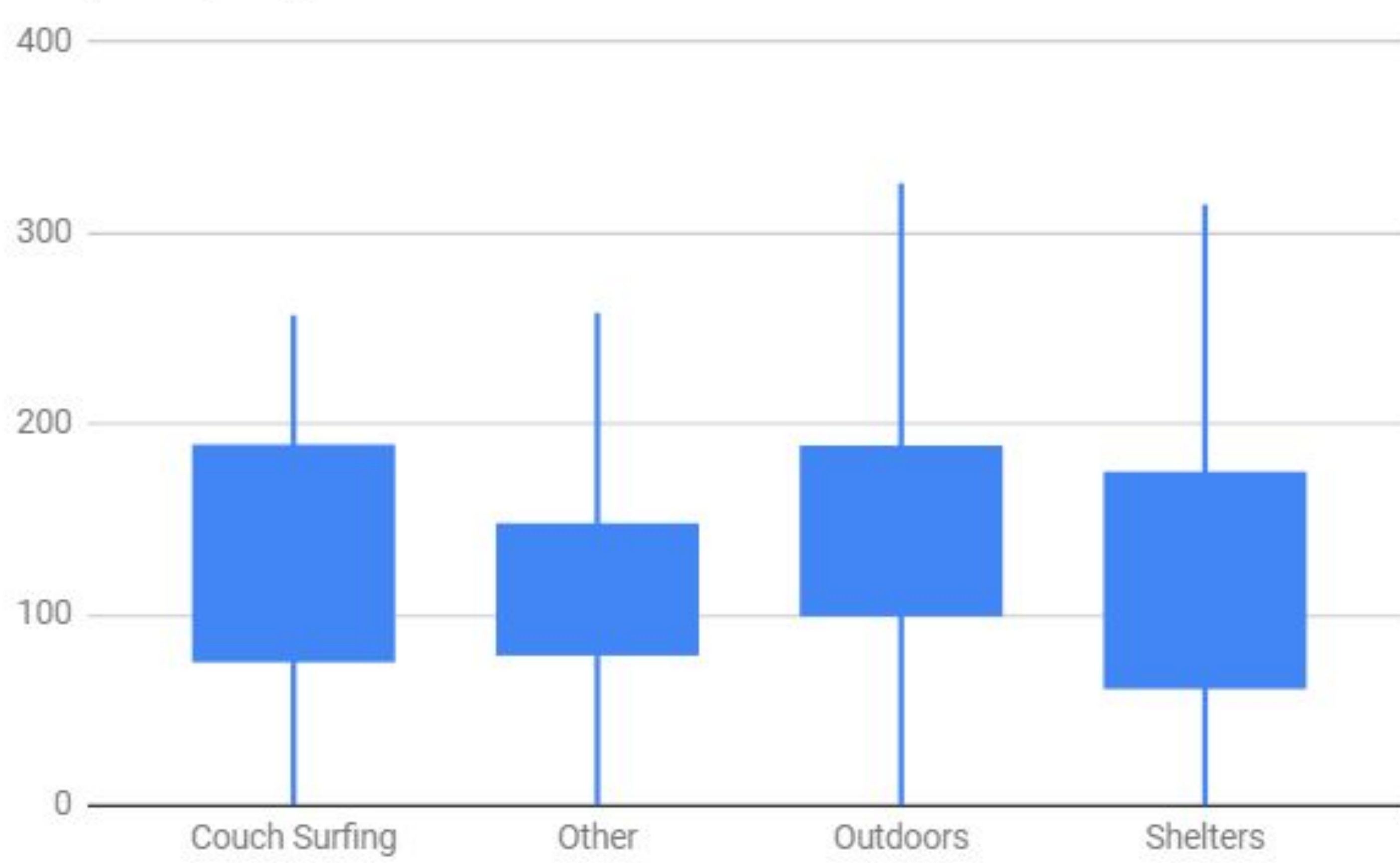

Program name vs Ethnicity
100%
75%
50%
25%
0%
Housing First
Rapid Re-Housing
Supported Referral
Other
NONE
Non-Status (Treaty)
No Response
Métis
Inuit
First Nations (Treaty)
Caucasian
Aboriginal (Not Specified)

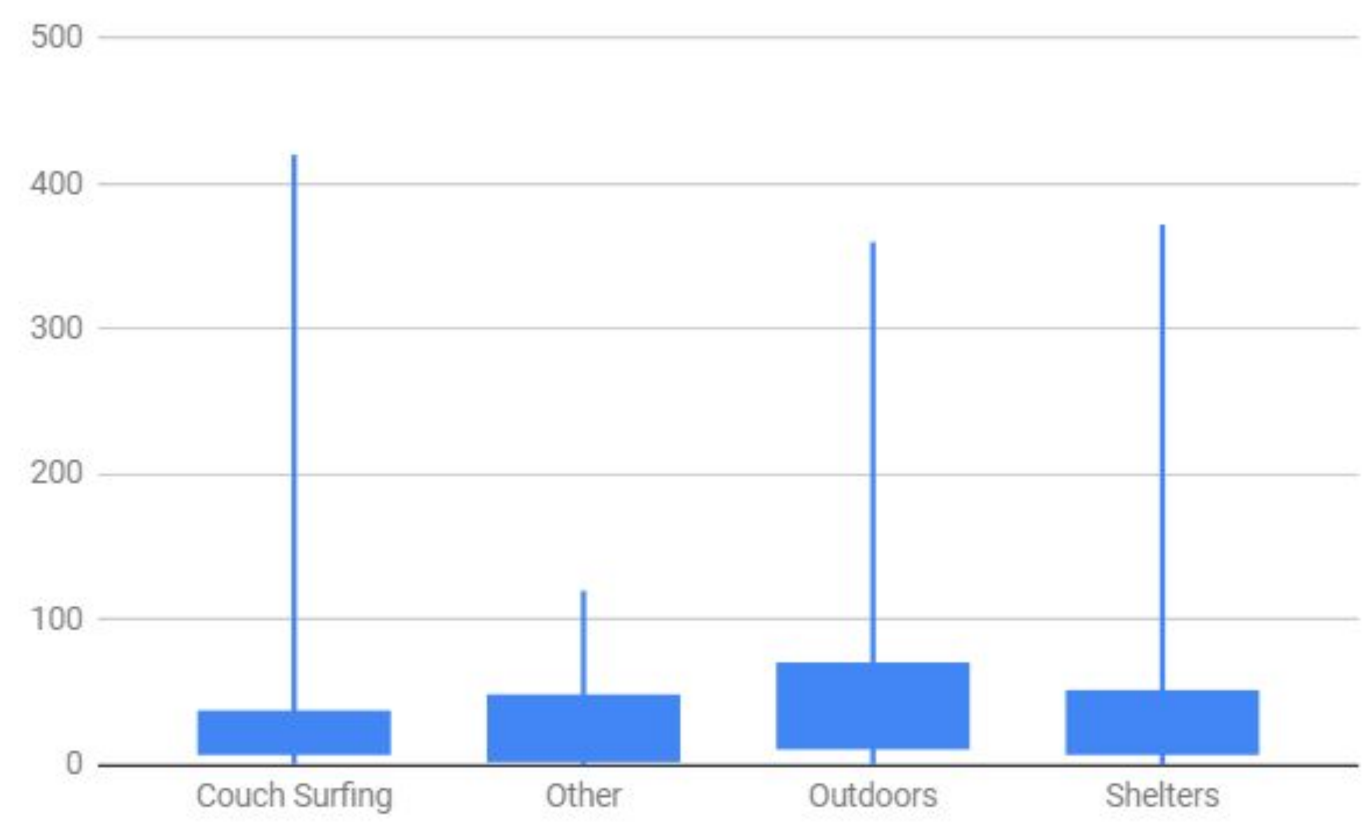

Age vs Current Location
80
60
40
20
0
Couch Surfing
Other
Outdoors
Shelters

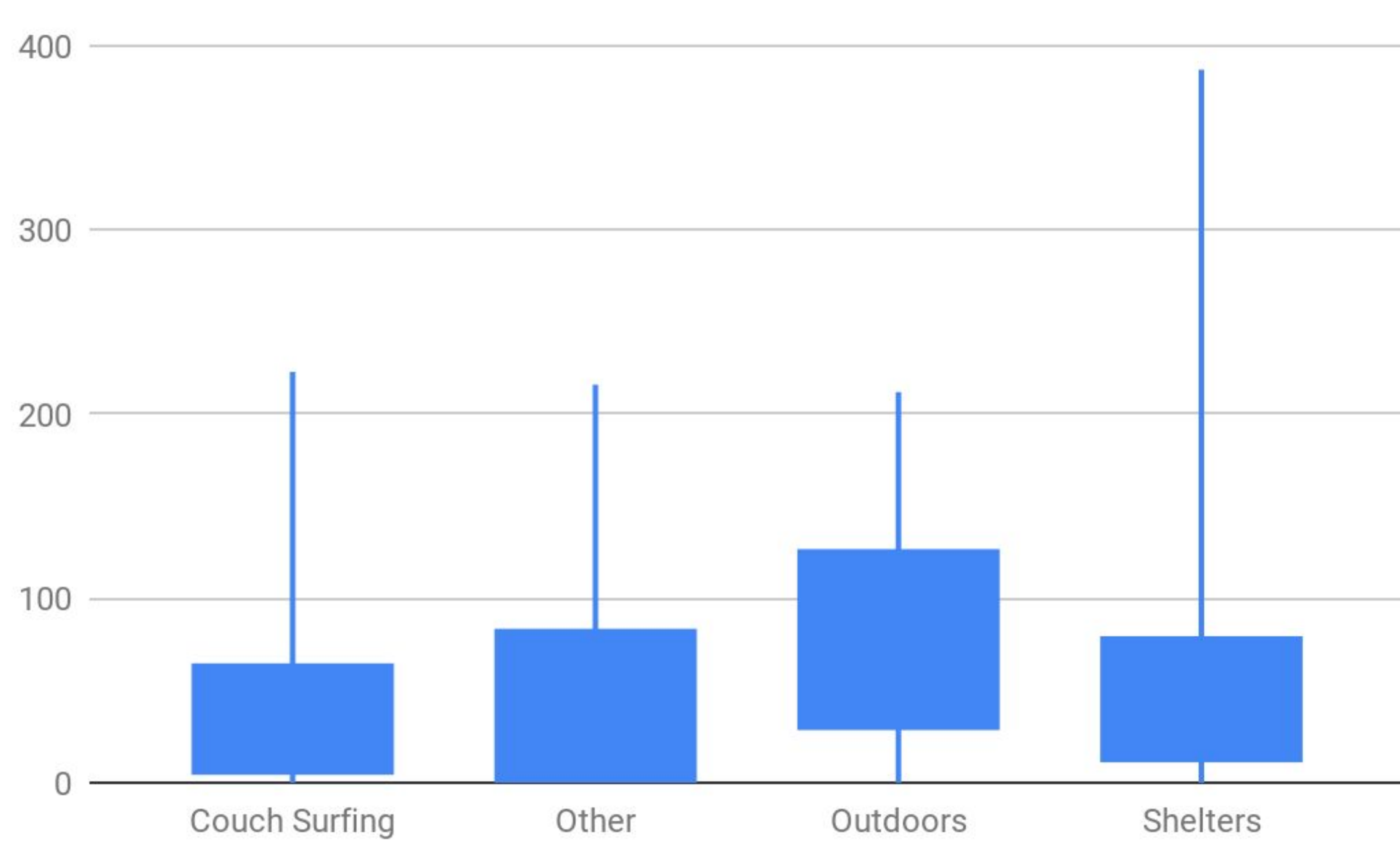

Current location vs Gender
100%
75%
50%
25%
0%
Couch Surfing
Other
Outdoors
Shelters
Male
Female

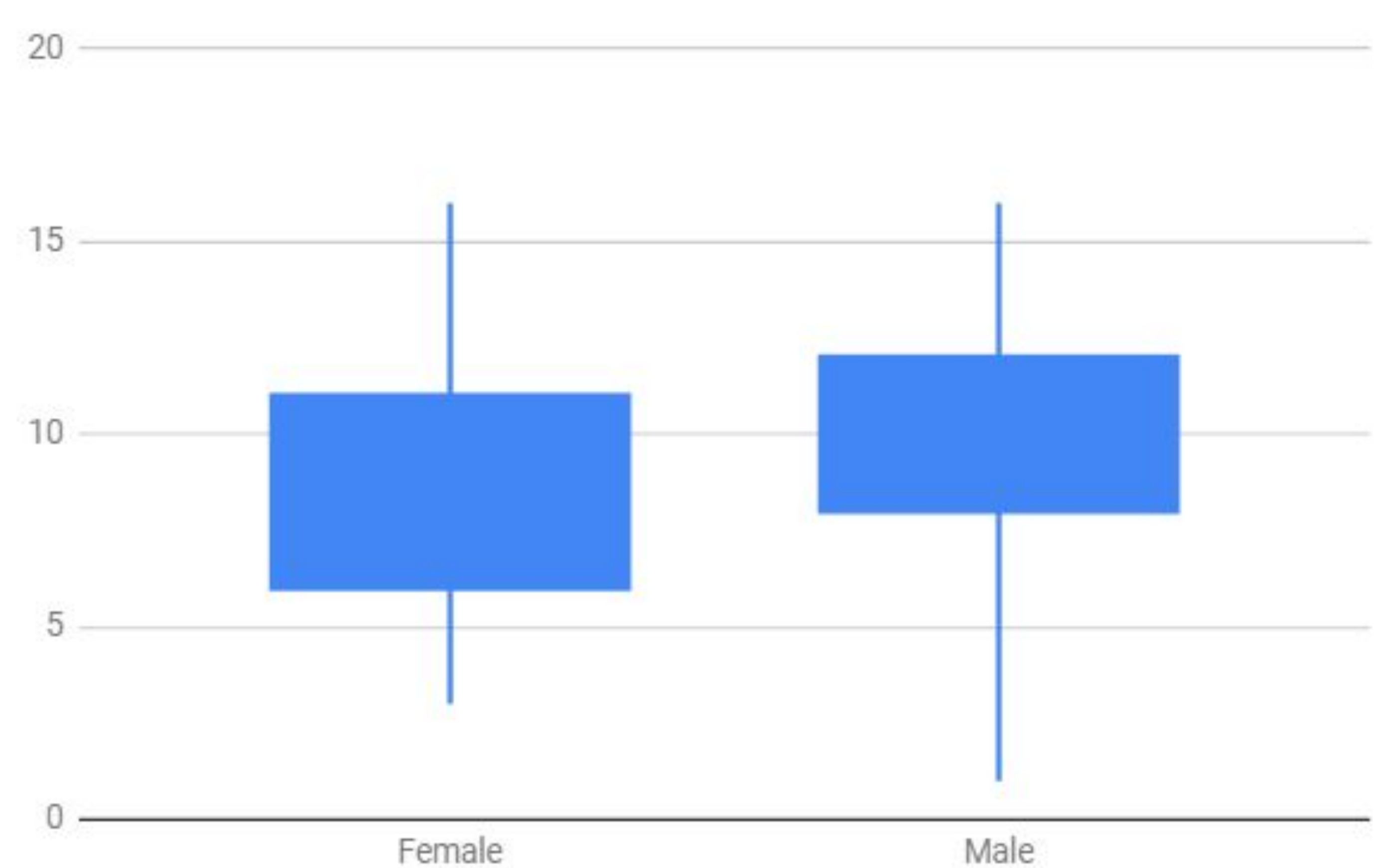

VI-SPDAT score vs Current Location
20
15
10
5
0
Couch Surfing
Other
Outdoors
Shelters

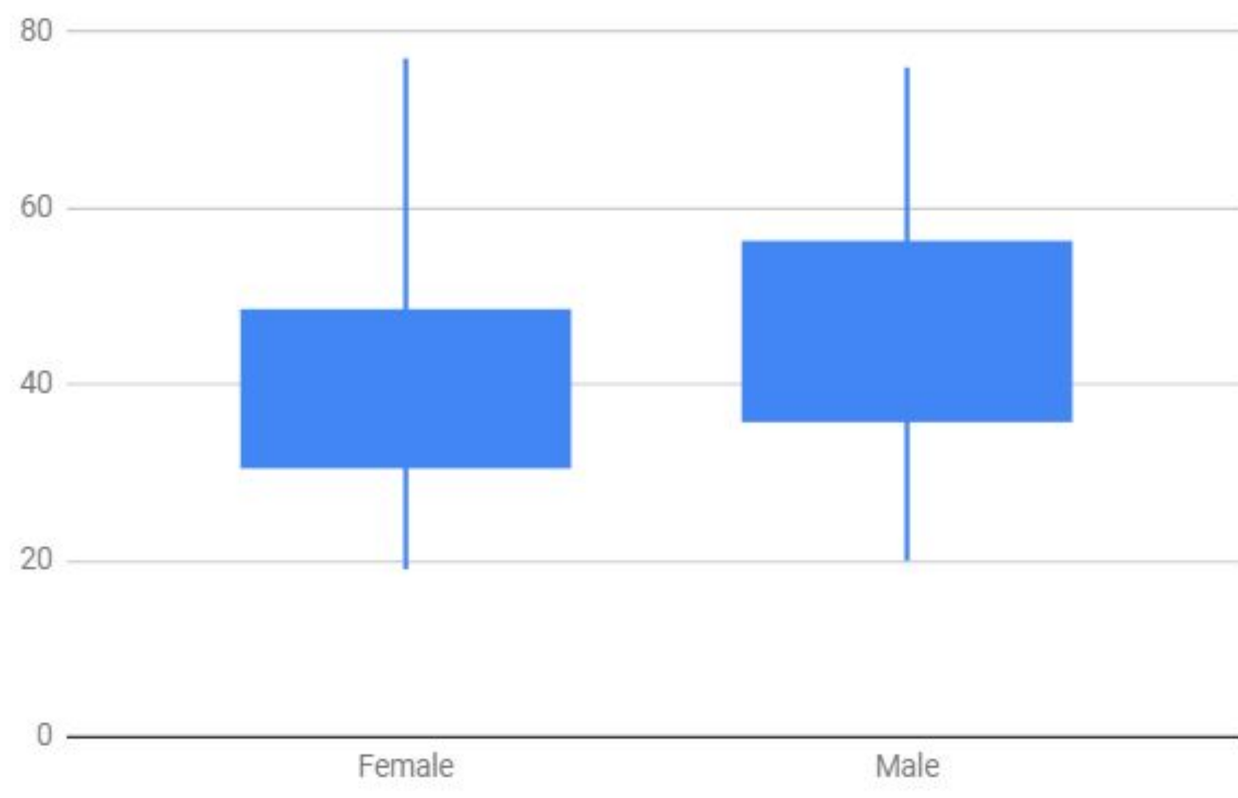

Current location vs Dependent
100%
75%
50%
25%
0%
Couch Surfing
Other
Outdoors
Shelters
Yes
No

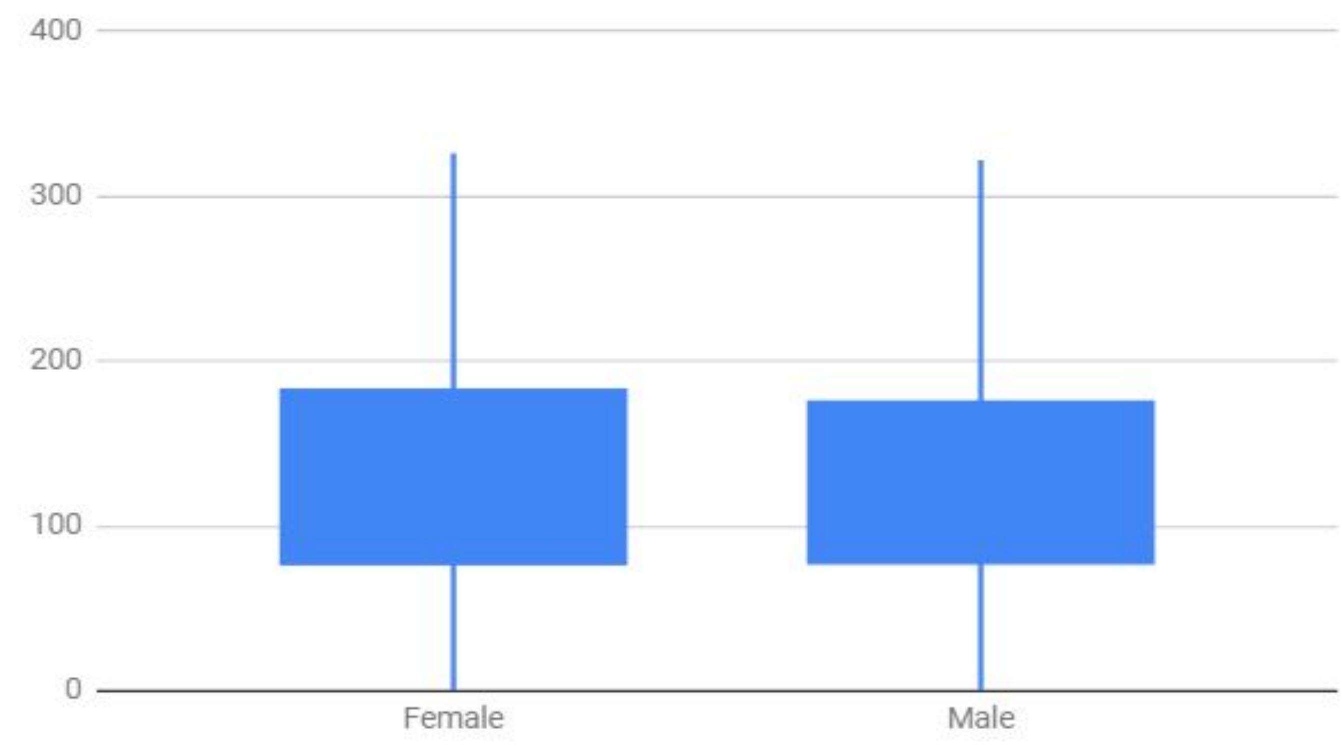

Days in program vs Current Location
400
300
200
100
0
Couch Surfing
Other
Outdoors
Shelters

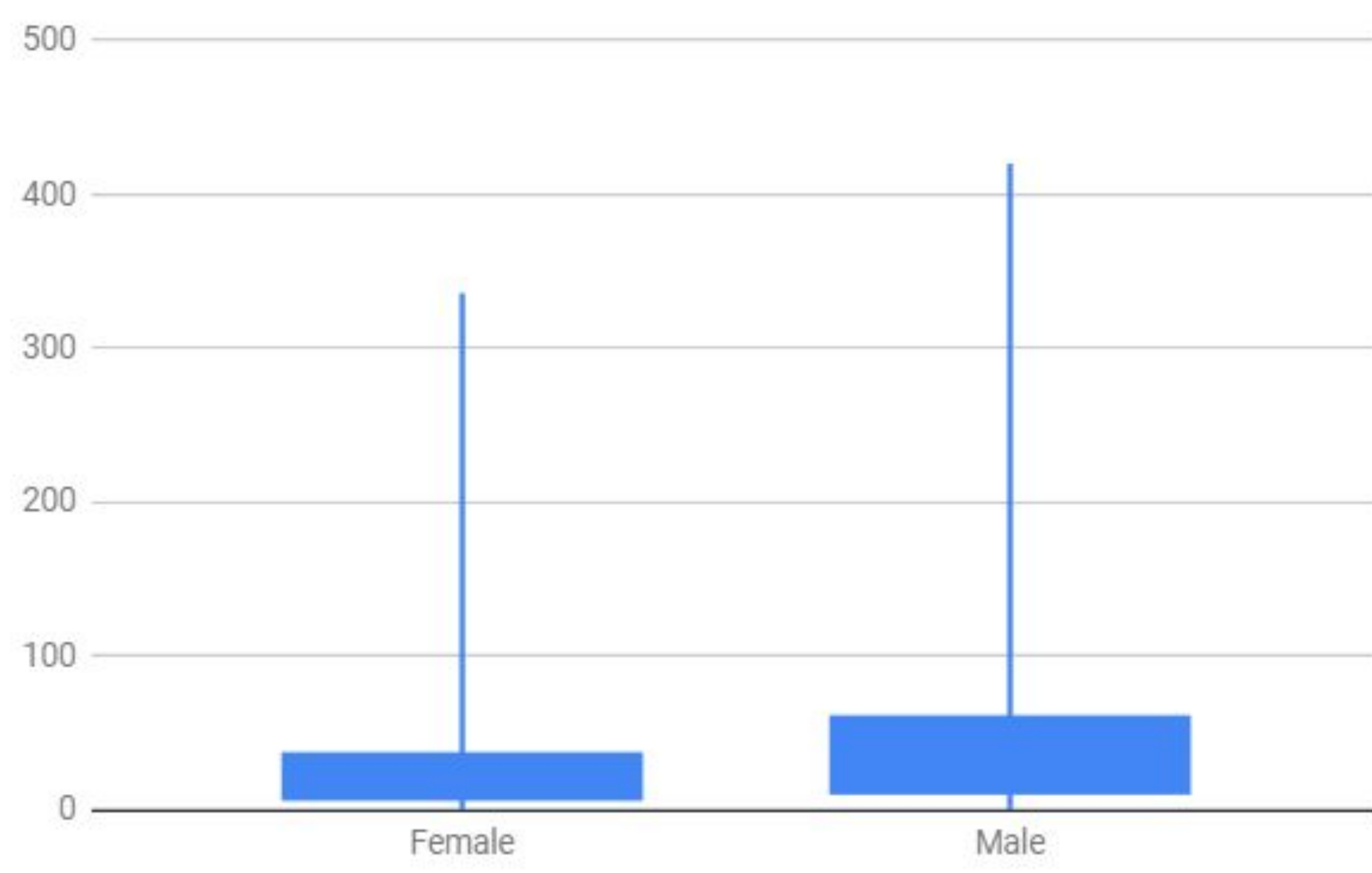

Months homeless vs Current Location
500
400
300
200
100
0
Couch Surfing
Other
Outdoors
Shelters

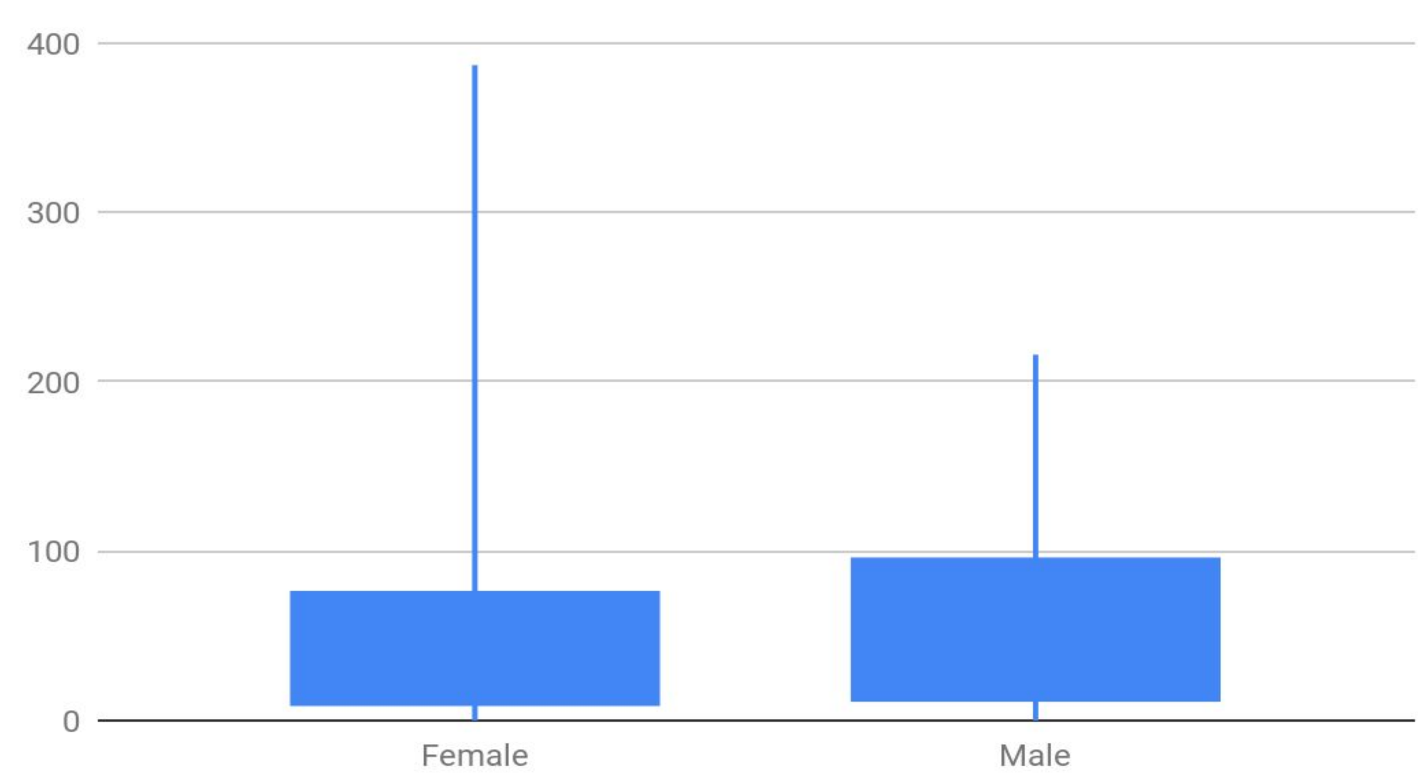

Time from Intake to Housing vs Current Location
400
300
200
100
0
Couch Surfing
Other
Outdoors
Shelters


VI-SPDAT score vs Gender
20
15
10
5
0
Female
Male


Age vs Gender
80
60
40
20
0
Female
Male


Days in program vs Gender
400
300
200
100
0
Female
Male


Months homeless vs Gender
500
400
300
200
100
0
Female
Male


Time from Intake to Housing vs Gender
400
300
200
100
0
Female
Male