Home for Good program: A mixed-method evaluation of a supportive housing model for people with experiences of homelessness

Picture from Mainstay Housing

June 2022

Land acknowledgement

We wish to acknowledge the sacred land on which MAP and Unity Health Toronto operate. It has been a site of human activity for 15,000 years.

This land is the territory of the Huron-Wendat and Petun First Nations, the Seneca, and most recently, the Mississaugas of the Credit First Nation.

The territory was the subject of the Dish With One Spoon Wampum Belt Covenant, an agreement between the Iroquois Confederacy and Confederacy of the Ojibwe and allied nations to peaceably share and care for the resources around the Great Lakes.

Today, the meeting place of Toronto is still the home of many Indigenous people from across Turtle Island, and we are grateful to have the opportunity to work in the community, on this territory. We are also mindful of broken covenants and the need to strive to make right with all our relations.

Acknowledgement

This evaluation was conducted as a collaboration between MAP Centre for Urban Health Solutions, St. Michael's Hospital and Mainstay Housing. The study was led by Dr. James Lachaud and Dr. Stephen Hwang, Co-principal investigators.

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Executive Summary

Supportive housing is a crucial part of the housing continuum and provides affordable housing and access to support services for people with experiences of homelessness. Mainstay Housing (now Houselink and Mainstay Community Housing), Toronto's largest non-profit housing agency, has participated and implemented a special social and supportive housing program called Home for Good (HFG) from November 2018 to November 2021, renewed for one additional year, November 2022. There were two components of HFG: the Move-In component provided stable housing and supports to 60 individuals, while the Move-On component aimed to support up to 60 previous long-term tenants who wanted to move into private market housing. The current study conducted by researchers of MAP Centre for Urban Health Solutions at St. Michael's Hospital, aimed at evaluating the implementation of HFG using a mixed methods approach. This executive summary outlines the key findings and provides a few recommendations below.

COVID-19 and HFG program adjustments: Due to the COVID-19 pandemic, HFG adjusted to follow public health measures to stop the spread of the virus. The Move-On component of the program was put on hold and then unexpectedly de-funded and closed. At the time that the Move-On component ended, ten long-term tenants had moved into private market housing, and 20 long-term tenants were still on the waitlist to move out. Through the Move-In component of the program, HFG contributed to reducing homelessness by housing 44 individuals, out of the original target of 60 individuals.

In addition, all HFG in-person activities, including counseling and other group activities, were put on hold to follow the public health measures. Many adjustments were made to support alternative service delivery models including distribution of cell phones and food, and renovations to the physical building structure. These adjustments allowed the program to avoid COVID-19 outbreaks within the building. However, these public health measures also increased social isolation and affected mental health, alcohol, and substance use of clients. Furthermore, due to COVID-19 restrictions there was a high-rate of staff turnover and burnout. Staff found that their efforts to support their clients' needs were limited as many of them were newly hired, with not enough time the build connection with their clients in the COVID-19 context. At the same time, most external services were closed.

Homelessness history and housing: Of the target sample of 15 individuals from the Move-In of the program, 12 agreed and provided consent to participate in the is study. All 12 participated in the quantitative survey and 11 participated in the qualitative interviews. The mean age of participants was 47.8, with a range of 23 to 72 years old. Eight participants self-identified as male, seven participants self-identified as white, three as mixed, and two as another race. One third of the participants had their first homeless experience before 18 years. Overall, time spent homeless varied from less than two years to 30 years. Most participants expressed feeling thankful to have a key their own home and for regaining some level of privacy, especially during the COVID-19 pandemic. However, some participants reported ongoing challenges such as pest infestations, street drug availability, and the repeated occurrence of deaths within the building.

Health conditions: Study participants had poor health conditions. Out of the 12 study participants, 3 (25%) reported one chronic disease (CD) and 8 (66.7%) reported two or more CDs. The most frequently reported CDs were related to homeless conditions and poverty including back pain 6 (50%), skin

problem 5 (41.7%), dental problems 4 (33.3%) or foot problems 4 (33.3%). Many participants reported severe mental health symptoms (5 or 41.7%) and high scores of alcohol and drug use (5 or 41.7%).

Basic unmet needs

Participants were living on monthly payment from Ontario Disability Support Program or Ontario Works. In 2020, these programs provided $14,028 or $8,796 per year, respectively, compared to the Ontario's poverty line based on Market Basket Measure of $20,057 per year for a single person for the same year. The participants also showed a high level of food insecurity (42%). Only 2 participants (17%) reported having a fair to good quality of life. Qualitative interviews with participants revealed that most support services that help meet their needs had deteriorated during the pandemic.

Program engagement and social integration: We found a lack of program engagement and participation in social and community activities in the month prior to the interviews. These findings were expected since HFG program activities were on hold, and the city was locked down due to COVID-19. However, many participants (40% or more) reported not engaging in community activities (sport or recreation, libraries, community events or coffee) because of other reasons not related to the pandemic, such as not being interested in the activities and not having time to engage. In the qualitative interviews with the tenants, they talked about their poor or weak ties with family members or friends. Many expressed that they felt lonely, isolated and had difficulty connecting with people.

Many participants reported that the housing support workers who were working with them were supportive, had close relationship and were available to assist them. However, other participants mentioned the peer worker who assisted in many of their activities was "let go" and never been replaced; they expressed that this created a vacuum which left them to have only interactions with the housing support workers. Some of them reported they felt uncomfortable or no heard or disconnected when dealing with their housing support workers.

Private Market Tenants: All 10 individuals who moved into private housing in the Move-On component and provided consent to participate in this study. The participants shared the challenges they faced in searching and applying for an apartment, such as not having government identification, a good credit score, proof of stable income, guarantors, social status discrimination and stigmatization for receiving social assistance. Assistance provided by the housing workers was crucial to finding a private market unit. Although the process was generally long and frustrating, participants expressed how they felt comfortable, more independent and happier in their new place. However, some participants also expressed new financial strains as they had new responsibilities and reduced access to support services.

Our findings support the following strategic recommendations.

1. **Making housing a cleaner and safer place, a home**: Feeling safe and secure in one's home is a right and fundamental to human well-being. Although stable and affordable housing is the main pillar of the HFG program, some issues like pest infestation and personal safety were not properly or fully addressed. It is important to develop or review the safety protocol of the program building to include a periodic disinfestation and pest control and drug problems.

2. **Using a more holistic approach to housing**: The provision of housing and supportive services are the pillars to supportive housing. However, this approach remains limited to addressing basic needs of individuals with recent long-term homelessness experience, and mainly those with mental health and chronic conditions. A more holistic approach is needed to include support for other basic needs like access to food, public transport, or care for some specific chronic conditions that result from homelessness and poverty like dental problems, back or foot problems. Building partnerships with community resources and health care services to support these and other basic needs is crucial.

3. **Revisiting the program activities to better build social connection**: Rebuilding social connection remains a major concern for people who have experienced homelessness, who felt abandoned and socially excluded. Although HFG program activities are designed to reduce social isolation, clients do not seem very interested in participating in them. A more inclusive approach in choosing or designing the type activities could increase clients' interest and participation. For example, the program can explore some outdoor activities like walking or jogging groups or hiking, which can help improve both social isolation and improve health. Working with recreation therapy agencies to develop socially interactive programs can also support the participants' engagement and social connection. In addition, peer workers can also play a key role in building social connection; their lived experience can facilitate building interpersonal connection and trust with the tenants, mainly for clients with histories of trauma and lack of social connectedness.

4. **More training and support for housing and peer workers:** Trust and feeling connected with the housing support and peer workers is key to supporting individuals with recent long-term homelessness experiences, especially those with chronic conditions and mental health problems. However, an emergency preparedness will help both housing and peer workers to feel safer, better trained and able to support their clients, mainly in case of a large-scale unexpected event like the COVID-19 pandemic or repeated death occurrences. In addition, high caseload a high-rate of staff turnover hindered this trust and connection building.

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List of Acronyms:

COVID-19: Coronavirus disease
CPP: Canada Pension Plan
CSI: Colorado Symptoms Index
ED: Emergency Department
GAIN-SS: Global Assessment of Individual Needs Short Screener (GAIN-SS)
HF: Housing First
HFG: Home for Good
HLMS: Houselink and Mainstay Community Housing
FI: Food insecurity
OW: Ontario Works
ODSP: Ontario Disability Support Program
QLI-20: Quality of Life interview 20 index
SHC: Supportive Housing Coalition
TTC: Toronto Transit Commission

1 Background

In the last three decades, Canadian federal and provincial policies and programs to address homelessness have shifted towards the Housing First (HF) model. Contrary to the traditional model, which provided housing on the use of services or adherence to treatment, HF is built on the principle of providing immediate access to housing, with preference to scattered-site housing in the private housing market and supportive services based on clients' choice (Aubry, 2014; Hwang et al., 2012). This model has been demonstrated as effective in facilitating the achievement of rapid and stable housing for individuals with experiences of chronic homelessness and mental illness (Stergiopoulos et al., 2021; Lachaud *et al.*, 2021) . Despite these results, an estimated 5 to 15% of HF participants struggle to achieve or maintain stable housing status (Aubry *et al.*, 2021, Lachaud *et al.*, 2021; Stergiopoulos *et al.*, 2021), and may require additional support, accompaniment to service providers, or on-site services (Patterson *et al.*, 2013; Mejia Lancheros et al., 2021). Additionally, private market housing, located mainly in urban centres with large homeless populations, is very expensive and limited in its capacity to meet housing demand (Raphael, 2010; Hanratty, 2017). Obtaining private market housing presents many requirements (e.g., rental deposit, job letter or tenant references) that socially and economically discriminate against people who are systematically marginalized, including people experiencing homelessness[1].

Social and supportive housing is seen as an alternative and complementary approach to providing affordable housing for individuals with experience of chronic homelessness and mental illness. (Tabol, Drebing, & Rosenheck, 2010). Mainly managed by social and non-profit agencies, many social and supportive housing programs in Canada use an adapted version of the HF model with on-site supportive services which can be tailored to clients' specific needs such as victims of domestic violence or with drug and alcohol abuse. Housing is not conditional on using the on-site services; individuals are considered tenants if they sign a lease and are protected by Ontario tenant rights (i.e., Residential Tenancies Act). They are also subject to tenants' obligations and the possibility of eviction, as any other tenant. These housing programs usually work in collaboration with community and health services, which contribute to the provision of services to tenants. The supportive services range from a basic "check-in", to social and recreation programs, alcohol and harm reduction programs, and other services to help residents enhance their way of living and achieve self-sufficiency. Many of these programs emphasize engagement and participation of tenants in activities to promote social inclusion and supports to promote well-being. Mainstay Housing, Toronto's largest non-profit housing agency, has implemented a special social and supportive housing program that applied this approach called **Home for Good** (HFG).

1.1 Contextualizing Mainstay and Home for Good (HFG) Program

Mainstay Housing, previously the Supportive Housing Coalition (SHC) of Metropolitan Toronto or the Coalition, has a long history of administering and delivering housing and support services to socioeconomically excluded groups. SHC was created in 1982 as a volunteer institution with one co-coordinator as its only staff member. Since its creation, SHC has adopted a holistic supportive housing approach, including an emphasis on recovery, consumer involvement in choice of housing, treatment and lifestyle, development of intentional communities and attention to delivery of high quality and

[1] Ontario Human Rights Commission, Right at home: Report on the consultation on human rights and rental housing in Ontario, May 2008), online: http://www.ohrc.on.ca/en/right-home-report-consultation-human-rights-and-rental-housing-ontario , accessed by December 2020.

responsive services. To achieve its mission of delivering services, SHC works with several partners, namely the City of Toronto, Metropolitan Toronto, the Ontario Ministry of Municipal Affairs and Housing, Canada Mortgage and Housing Corporation, and local mental health service agencies. To better address clinical and non-clinical support service issues, SHC signed a Support Service Agreement (SSA) with its agency partners in 2004, restructuring the institution and redefining roles and responsibilities. At the same time the name of the organization was officially changed to Mainstay Housing (7). Most recently, in 2021, Mainstay Housing amalgamated with another supportive housing organization called HouseLink Community Homes, in order to increase their capacity in the sector.

In 2018, Mainstay Housing launched a housing-integrated program called **Home for Good (HFG**) for homeless single adults with experiences of chronic homelessness. Supported by a dedicated program manager, HFG is an Ontario government funded program with the following two components.

The first component of the program, Move-In, provides immediate access to self-contained units in a single-site building for up to 60 people who were either sleeping on the street or in shelters. To be eligible for a unit, individuals must have been referred by the City of Toronto. In addition, this component includes on-site supportive services by five housing workers and a peer-support worker.

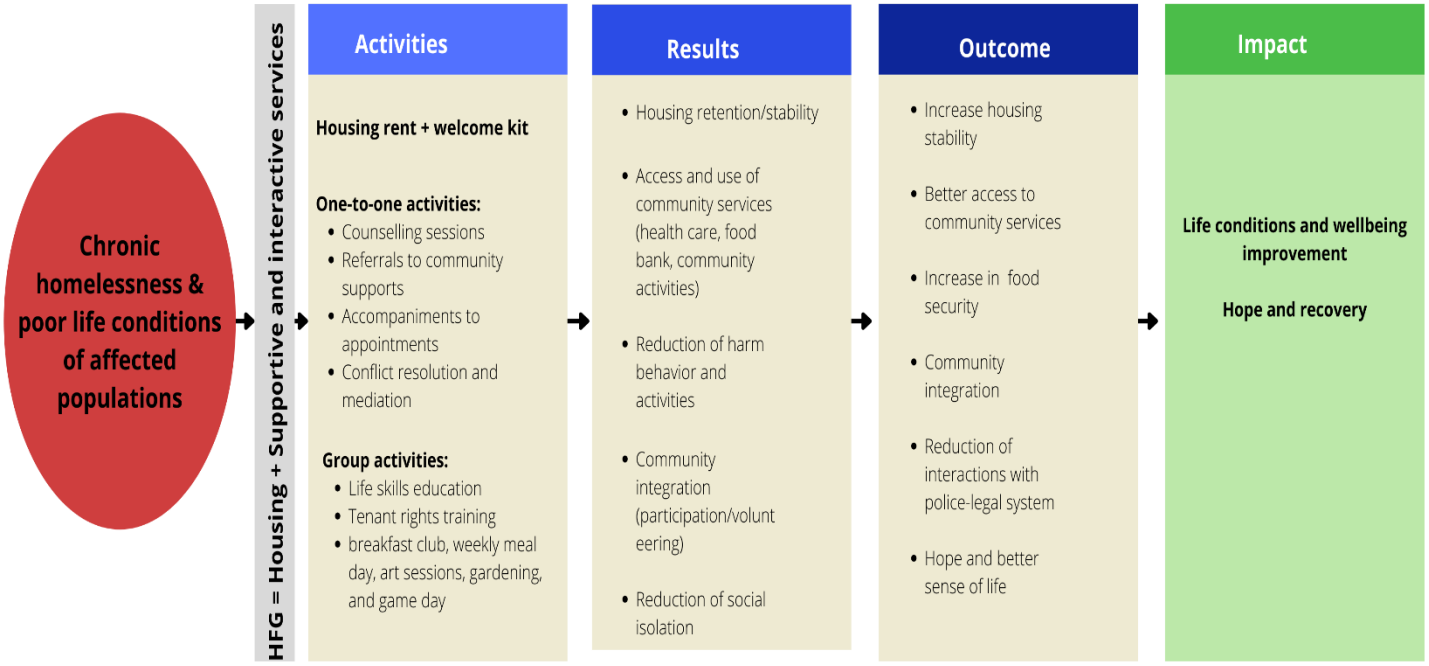
The supportive services are intended to extend over the **first three years of tenancy.** During the first two years, tenants are offered a large variety of supportive services, including mapping and referral to community services such as primary health care services or food bank, appointment arrangement and accompaniment to services, individualized support plans, peer support counseling, and education on tenancy rights and responsibilities. Moreover, several community development activities are also offered such as psychoeducation substance abuse group activities, a tenant-led hot meals program, and gardening days. Attendance at community activities **is not mandatory and not a condition for the receipt of housing**. Tenants were also given the option to connect to a case manager in addition to a Supportive Housing Worker during their tenancy in HFG.

In the third year, referred to as the step-down phase, tenants are connected to case management services within the system of care to provide them with moderate supports and ensure they sustain the accomplishments they have made. Tenants continue to receive supportive services and are monitored during the third year to ensure their continued success. **Housing support is permanent and continues beyond the three years of supportive services**.

In this evaluation report, individuals who are enrolled and remain tenants in the HFG program are referred to as clients.

The second component of the program, **Move-On**, provides support to longstanding Mainstay Housing tenants who are ready to move on to private market housing. Some tenants have been residing in a Mainstay Housing supportive building for more than 10 years. The Move-On component offers tenants a rent supplement of up to $800 CAD per month and access to off-site moderate supports such as assisting with negotiation between client and landlord. Also, tenants are offered the possibility to return to a Mainstay Housing building in case they experience difficulty integrating into their new housing and community environment. Move-On phases uses a recovery and consumer-centered approach to ensure tenants are aware of expectations of living independently and therefore are assessed by program manager to ensure tenants are ready transition to an environment that does not have an on-site supportive services. The HFG catalyzing rationale is summarized in the following **Path Diagram model:**

Figure 1. : Path Diagram Home for Good Model (Move-In component)



1.2 Home for Good and the COVID-19 context

As with most supportive housing programs, HFG was not initially designed with specific strategies to mitigate the adverse effects of a large-scale and unexpected event such as the COVID-19 pandemic. In the context of COVID-19, Canada's (and the city of Toronto's) pandemic lockdowns closed all non-essential public services and activities (e.g., libraries, public parks, non-essential health services, group meetings). In light of this new context, several HFG program activities were put on hold, especially group-based activities such as community gardening, and others had to be adjusted to minimize in-person interactions. Among such adjustments, there was the distribution of mobile phones to facilitate communication and supportive counseling services to tenants, and food distribution to the door of tenants most at risk of food insecurity. Congregate supportive housing can be challenging because living in the same building increases risk of exposure to a highly contagious virus. This can provoke disruption of delivery of services to tenants. At the same time, supportive housing can enable rapid coordinated responses in a timely manner by reorganizing or adjusting services, eventually providing additional support to tenants, as well as connecting them with alternative supports available in the local communities.

Moreover, the COVID-19 context was (and still is) an evolving and ongoing situation. HFG, as well as other supportive housing programs, needed to constantly review and adjust their programmatic actions and activities to protect and serve their tenants, while also protecting staff and limiting potential spread of the virus within the building. Therefore, this evaluation offered the opportunity to document the adaptations and response strategies of a supportive housing program like HFG in the context of COVID-19 and to assess how COVID-19 affected clients' well-being outcomes.

With the above in mind, a partnership agreement was developed between researchers at MAP Centre for Urban Health Solutions located at St. Michael's Hospital (Unity Health Toronto) and Mainstay Housing to conduct a 2-phase evaluation of the HFG program. MAP is an internationally recognized centre for homelessness research and its researchers have extensive experience in successfully conducting and evaluating interventions to improve housing stability and quality of life among homeless adults and other socioeconomic excluded social groups, such as people with histories of incarceration, substance use and mental illness.

2 Objectives of the evaluation

This study is the first phase of the evaluation of the HFG program. It undertakes an analysis of baseline data to evaluate the success of the HFG program in meeting its set objectives and documents the strategic adaptations of the program during the COVID-19 pandemic. This paper provides rapid appraisal to measure and assess the main program indicators of the HFG program, both the Move-In for new HFG program clients and those enrolled in the Move-On component, in the COVID-19 context. In particular, we aimed to:

- Document the adaptation of HFG program activities due to the COVID-19 pandemic;
- Measure and assess to what extent the COVID-19 context affected HFG client outcomes, including housing outcomes, program engagement and community integration, chronic health conditions, mental health, alcohol and drug use issues, acute health care utilization, food security, and quality of life;
- Assess the transition to private market housing of tenants enrolled in the Move-On component.

3 Methodology

In this study, we used a mixed-method approach, collecting both quantitative and qualitative data, with a triangulation design to integrate and analyze data collected through surveys, interviews, and a focus group (Cresswell *et al.*, 2009). At the time of this evaluation, for the first component, Move-In or new tenants' group, the HFG program enrolled 44 tenants. For the second component, the Move-On group, there were 10 tenants who moved into private housing market and approximatively 20 others who applied or expressed the willingness to move into the private market; we classified the last category as the "In-Transition" group.

3.1 Sampling

Since the HFG program enrolled a lower number of participants than the initiative aimed, we used a purposive, non-probabilistic sampling method, in which participants were selected to represent the two components of the program as well as the housing and peer-workers. For the first component of the HFG program (the Move-In group) the survey aimed to select a sample of 15 clients, to participate in both quantitative and qualitative interviews. For the Move-On component, we sampled 10 clients from each sub-group, Move-On and In-Transition to participate in qualitative interviews. Finally, a focus group was also conducted with 4 housing support workers and the peer-worker.

The enrolment of study participants took place from December 2020 to May 2021. All tenants were contacted through informational flyers containing information about the evaluation and its objectives, methods, and team members. The flyers were distributed by program staff and housing workers. Individuals were asked to contact the research team by phone or email to express their interest to participate or provide the program staff with permission to provide their contact information to the research team to be contacted. Recognizing the financial and time burden associated with participating in research, participants received an honorarium in the amount of CA $30 per interview.

3.2 Survey tools and interviews

We developed a questionnaire to obtain quantitative data (see the table of the main outcomes/indicators in Appendix), and an interview guide for the qualitative interviews with the participants of the Move-In group. The interview guide was divided into 7 sections focused on housing, social relationships, program participation, food insecurity, quality of life, health care utilization, and interactions with housing workers and peer-workers. For the Move-On component, the interview guide for the qualitative interviews included questions on the reasons they moved into the private housing market, the application and transition process, and life conditions and hopes after moving into independent housing. Finally, we also develop a focus group guide for housing workers and peer-workers, which contained questions on how COVID-19 affected the delivery of program activities and services and their interactions with clients.

Both quantitative and qualitative Interviews with clients and the focus group with staff were conducted through Zoom by the research team. The qualitative interviews and the focus group were audio-recorded and fully transcribed. All interviews and the focus group were de-identified to protect the identity of participants.

3.3 Data Analyses

Data collected from the focus group were combined with internal documents (i.e., activity reports) and regular meeting discussions with program management staff to describe and understand strategic changes in the HFG implementation due to the COVID-19 pandemic and potential impacts on the

expected outcomes for clients. Quantitative data and narratives from qualitative interviews were integrated and analyzed jointly to have a comprehensive and illustrative description of participants' experience with the HFG program. The results were presented in a workshop and brainstorming session with HFG management, staff and Housing Support Workers to develop actionable strategies and recommendations.

3.4 Research ethic approval

The study received ethics approvals from the Research Ethics Board at St. Michael's Hospital in Toronto, Canada. All study participants provided informed and written consent to participate in the study.

Table 1 below summarizes field activities and tools used for data

Table 1. Field activity

Participants' groups	Quantitative Survey (realized#/target#)	Qualitative Survey (realized#/target#)	# of Focus group
Move-In: New tenants	12/15	11/15	N/A
Move-On or private market group	N/A	10/10	N/A
In-transition group	N/A	9/10	N/A
Staff and housing workers	N/A	N/A	1/1*
Total	**12/15**	**30/35**	**1/1**

*The focus group was conducted with 5 participants, four housing worker and the peer-worker.

3.5 Difficulties encountered

We encountered some challenges during the recruitment and interviewing process. The main difficulty was that some participants could not attend the scheduled interview meetings, which required the research team to postpone and reschedule some interviews. We also experienced issues with internet connectivity, but those were quickly resolved. Lastly, a few (2) participants asked to complete the interview over multiple shorter meetings, which was done to facilitate their participation.

The findings of the study are described in the following four chapters. **The first chapter** will present the amendments to the program service provision due to the COVID-19 pandemic. **The second** will describe the housing experiences, well-being and life conditions of the main target group of HFG group, the Move-In group. **The third and fourth chapter** will be present the findings for the In-Transition and the Move-On groups, respectively.

4 COVID-19 Context: Revisiting HFG program objectives and the activities

As with most organizations that provide in-person social services, the social and supportive housing sector was not designed to face a large-scale and unexpected event like the COVID-19 pandemic. To reduce the risk of rapid spreading of the virus, strict public health measures were widely imposed, including sanitation and protection procedures (wearing masks and hand hygienic measures), physical distancing, and city lockdown periods for most non-essential services and activities (e.g., libraries, public parks, non-essential health and social services, group meetings). Additionally, supportive housing programs had to re-engineer their service delivery, educate and train staff to meet new needs, reframe the implementation of group-based and community activities, in-person contact and counselling sessions, and authorized visits (i.e., family members). In the face of these challenges, we documented the issues and adjustments implemented in the context of COVID-19. We reviewed changes presented during regular monthly meetings with HFG management staff over a 6-month period and those presented in the focus group with Housing Support Workers and one Peer-Worker as the frontline staff working directly with the tenants. Out of a total of 6 staff of the HFG program, 5 participated in the focus group 4 Housing Support Workers and 1 Peer worker. Of these, 3 were men and 2 women.

Four main issues and strategic adaptions were identified through monthly meetings and the focus group: (1) revision of the target numbers of program participants; (2) redesign of HFG activities, (3) mental health concerns, and (4) staff burden and exhaustion.

4.1 Revision of the objectives of the program

One of the first changes made by HFG management as a result of the COVID-19 pandemic was to lower the target numbers of program participants. The program was initially designed to house up to 60 individuals (Move-In), and to provide support to approximately 60 individuals to move to the private housing market (Move-On). Out of those targets, only 44 people were successfully enrolled in the *Move-In group,* from which 37 remained housed, five have died, one moved out of town and one did not like the building and moved out. Out the target of 60 individuals for the Move-On component, only 10 *clients moved to private housing market.* During the early wave of the pandemic, the Move-On component was completely halted and then de-funded by the Provincial government. This decision left approximately 20 tenants who were qualified for the Move-On component were placed on a waiting list, with no clear expectation of when they could to move out in the near future. The Move-In component continued at a very slow pace, since there were limited units available without the Move-On component. Priorities of the HFG management staff also shifted from enrolling new tenants to revisiting the programmatic activities while following all public health measures ordered by the federal and provincial government to avoid COVID-19 potential outbreaks.

4.2 Resdesign of HFG activities

After the COVID-19 pandemic was declared on March 11, 2020 and after the first lockdown in Ontario was decreed on March 23, all in-person and group-based activities were put on hold, including individual counselling sessions, accompaniment to health and other services, meal and gardening days and outside activities. New priorities emerged, mainly focused on facilitating access to personal protective

equipment (masks, gloves, and hand sanitizer), access to food banks for food as well as delivery of food to tenants at higher risk of infection (elderly or with severe health issues). With support from local and tech companies, smart phones were distributed with an internet paid option of $10 CAD monthly. Access to smart phones facilitated the transition of some in-person activities into tele-activities including individual counseling or accompaniment of tenants to telemedicine. However, some tenants declined or had difficulties using smart phones or paying monthly fees for internet access. A few individuals lost or sold their smart phones. To reduce the risk of disease transmission, HFG management undertook some renovations or adaptation of space within the building, including creating new counseling room spaces with Plexiglas, as well as renovation of a staff room to facilitate their work and ensure social distance and sanitation measures.

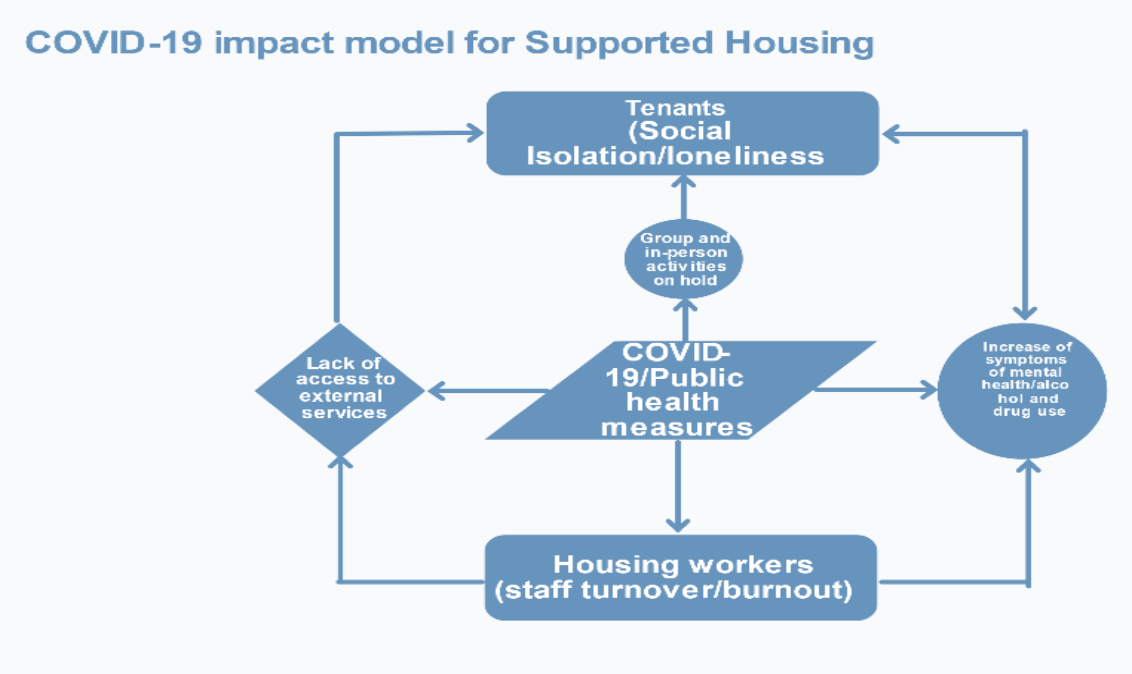
4.3 Lack of Resources to address mental health concerns

The focus group participants reported that social isolation and the subsequent deterioration of the mental health of their clients were major concerns. Since almost all in-person activities were put on hold, their clients became more socially isolated because of limited in-person interactions both inside and outside the building. As a result, housing and peer-workers observed an increase in alcohol and substance use among clients, and signs of deteriorating mental health manifested as symptoms of depression and anxiety. Workers also reported about the limited availability of mental health care services from the community and health care providers during the spread of the pandemic. Therefore, they felt they were not properly trained or prepared to provide adequate and adapted mental health assistance to their clients. This situation made them feel powerless and frustrated.

4.4 Staff turnover and burnout

It is important to mention the high rate of staff turnover and burnout during the pandemic. Out of the five housing and peer-workers who participated in the focus group, only one had been with the HFG project since the beginning. The other four had been newly hired between three to nine months before the focus group meeting. Many of them were still in their probationary period. One housing worker and the Peer-worker left or had their contract terminated approximately two months after the focus group interview. Our inquiry with the Program Manager indicated that their termination was not related with the interview or the study. The Peer-worker was not replaced for the rest of the program. Newly hired housing workers usually need some time to get to know clients and build trust. This factor, combined with limited contact due to the pandemic, made it difficult for them to assess their clients' health status or specific needs.

In sum, the COVID-19 pandemic affected both the HFG program objectives and rationale by lowering the number of individuals enrolled and hindered the implementation of many of the expected core activities. In addition, it impacts on social Isolation and loneliness of tenants and symptoms of mental health/alcohol and drug use, while made it more difficult to connect tenants to health care services and other external services. Housing workers had to face these new challenges, with limited resources and not adequately trained and prepared, which led to ahigh-rate of staff turnover and burnout.



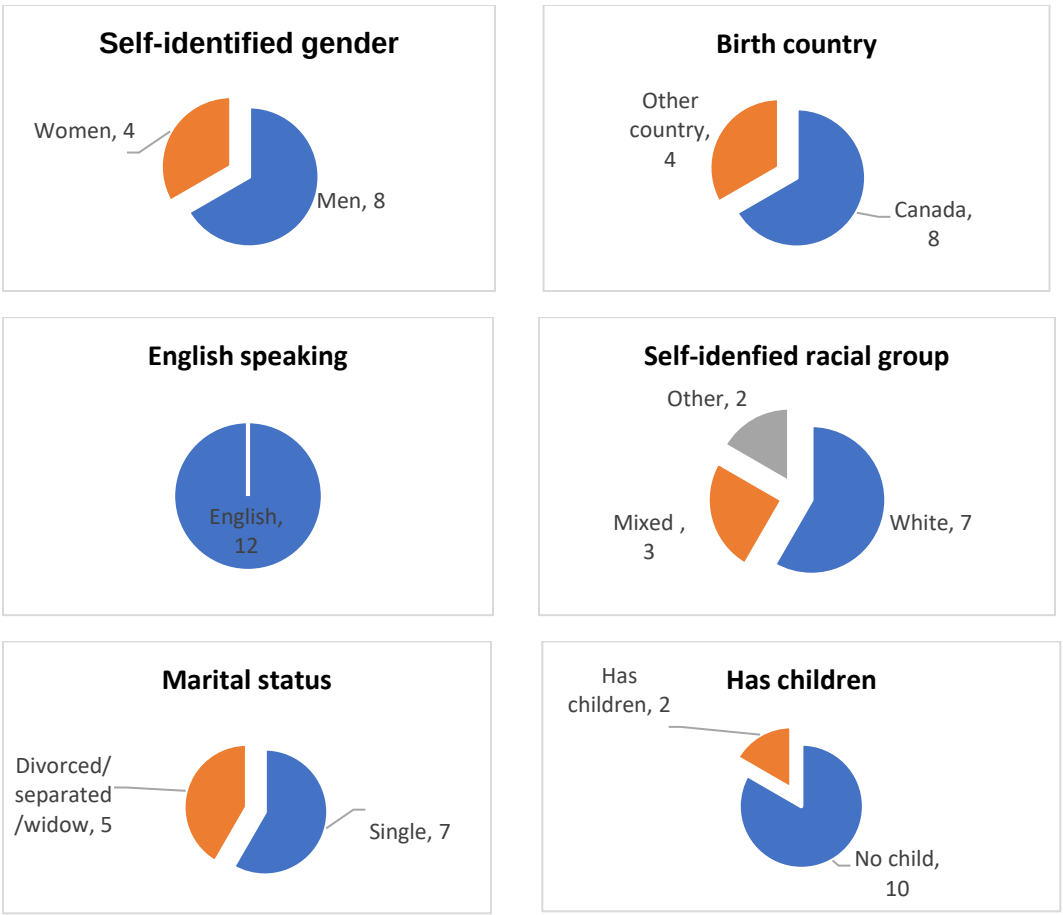
5 Move-In participants

This section of the report will discuss results for the Move-In participants. As illustrated in the figures below, the participants are a very diverse population. Out of the 12 participants, eight self-identified as men and four as women. They were on average 47.8 years of age, spanning a range from 23 to 72 years of age. The majority were born in Canada (8) and all of them spoke English. In terms of their ethno-racial background or identity, seven self-identified as white, three as mixed race, and two as other backgrounds. Participants' marital status varied, with seven declaring being single and five divorced, separated, or widowed. Only two had children.

Table 2. Age of the Move-In participants

Age (n=12)	
Mean Age	47.8
Std. Deviation	14.2
Age min	23
Age max	72

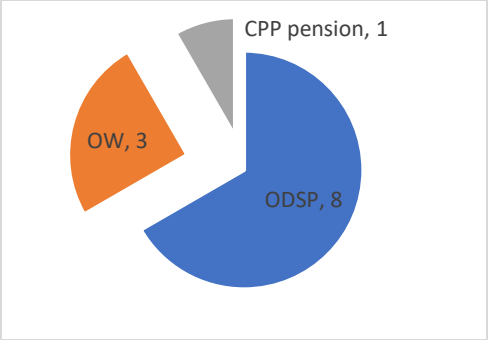
Figure 2. Sociodemographic profile of the Move-In participants



5.1 Socioeconomic conditions

In terms of economic situation, eight out the 12 were receiving Ontario Disability Support Program (ODSP), three were receiving Ontario Works (OW), and only one was receiving Canada Pension Plan (Figure 3). In 2020, these programs, ODSP and OW, provided $14,028 or $8,796 per year for a single person, respectively. These payments were 30% and 56.1%, respectively, lower than the Ontario's poverty line of $20,057 per year for a single person in 2020.

Figure 3. Income source



5.2 Homeless histories

The journey into homelessness of the study participants varied from person to person. As shown in **Table 4**, one third of participants (4 out 12) had their first homeless experience before the age of 18 years, while others (2) after they were 50 years old. Participants' transitions in and out of homelessness, homelessness episodes and lifetime duration of homelessness varied widely across the participants. (Table 5). Some moved from shelter to shelter while others alternated between couch surfing, shelter, street, and jail. Overall, the lifetime duration of homelessness ranged from less than 2 years to 30 years.

Table 3. Age at first homeless experience (n=12)

Age	n	%
Before 18 years	4	33.3
18-49 years	6	50.0
50 or more	2	16.7

Table 4. Homelessness History: First 5 Homeless Episodes

	Homelessness episode trajectories*					Lifetime duration of homelessness**
Participants #	E1	E2	E3	E4	E5	

1	shelter					Less than 5 years
2	shelter	shelter	shelter	streets	shelter	5- 10 years
3	streets	streets	couch	streets		**10 years or more**
4	shelter	shelter	street	shelter		Less than 5 years
5	shelter	street	couch	street	shelter	**10 years or more**
6	street	couch	shelter	street	shelter	5- 10 years
7	street	couch	shelter			Less than 5 years
8	street					**10 years or more**
9	street	couch	street	street	street	**10 years or more**
10	shelter	street	shelter	group home	group home	5- 10 years
11	shelter	shelter				Less than 5 years
12	shelter	shelter	shelter	shelter	shelter	5- 10 years

* There is only one participant with jail experience as a homeless episode. So, we removed it (Jail), and replaced by street to avoid any re-identification process.
** Range from 2 to 30 years.

Participants' different homelessness histories were also reflected in the qualitative interviews. Many reported difficulties in securing stable housing or receiving housing assistance. Additionally, their experience with chronic homelessness was challenging because of co-occurring mental health issues.

> *"I was homeless for the last ten years of my life and I've had a really, really rough time as a young man living in the city, securing stable housing, spent a lot of time on the streets, a lot of time going to different drop-ins around the city, spent a lot of the times within shelters and stuff like that."*

> *"The last 10, 15 years of my life have been basically a rollercoaster, I had some addiction issues and whatnot and maybe some undiagnosed mental issues like depression"*

> *"I moved in the building on (Date). It is like being this is the first time I've ever been in this situation before i.e., like you know assisted help with housing because before (I was) middle-class (and then) a certain situation happened and (I) had to go into the shelter system"*

> *"About 14 months ago I got released from jail. I just finished doing a year in the [Jail name] This is the longest I've been out of jail in a long-time cause unfortunately I've had an on again, off again addiction problem over the years."*

5.3 Housing experience: stability and evictions

Out of the 44 people who were in the *Move-In group*, HFG management reported two evictions and five deaths. The remaining participants were stably housed in the building. We asked participants questions in order to understand their experience of transitioning out of homelessness. These questions included, **feelings about their initial time with Mainstay; what having housing meant to them; and the level of safety they felt within the building.** Additionally, participants were asked about what it meant to have housing in the context of the COVID-19 pandemic.

5.4 The first two weeks living in supportive housing

Participants had mixed feelings during their first few weeks in the program. Some participants felt good because the stressors of their life before moving into housing were reduced and they reported a sense of safety and security in having their own apartment. Overall, participants felt good about having housing after experiencing homelessness for a long time.

> *"I mean it felt great. You have your own key, you feel secure behind your own locked door, you don't have anybody coming in or looking in at you or anything like that. You feel pretty secure."*

> *"it was a really good feeling [Laugh] honestly because not being in it for a long time and now that you have found a place where I was so [Pause] thrilled about it"*

> *"It was good because where I was I was stressed out and those things. Thank God I get out of there and to in here."*

During the first few weeks, some participants recalled having a hard time adjusting to their new environment. There was dissatisfaction regarding the cleanliness and safety conditions of the building. It was also difficult for some participants who moved in with few material belongings to feel safe and comfortable in their apartment.

> *"It was scary [Laugh] but not because again I was, I was actually going back into my old neighborhood. I knew the area very well but moving into this particular building you know they were saying you know it's infested and you know it should have been, and just the amount [number] of men like the population from men to women. And I got, I've been thrown around a couple of times"*

> *"It definitely was very difficult. At first, I really moved with nothing. I literally had a bag of clothes and that was it. No, furniture, nothing to eat out of, anything like that besides the stuff that was given to me as a welcoming package presented by the building, I literally had nothing and it was very difficult."*

5.5 Housing/home meaning

Participants highly valued the privacy they gained from having their own apartment. However, they also recognized the role of their new home in protecting them from the harsh weather and lifestyle conditions of living on the streets.

> *"it means a lot to me in a way that I am not you know [Pause] knowing that I'm in my own apartment. I have my own little privacy to do whatever I want to do"*

"Just having it because of the cold weather and also the reckless lifestyle and having the triggers around being homeless and being downtown cause a lot of people were using [drugs], it's in your face."

"To have this housing it's been good. It's been nice to have a place to go back to, to not stay outside too much."

5.6 Housing during the COVID-19 pandemic

In the context of COVID-19, several participants expressed being thankful and feeling blessed to have housing at Mainstay because it allowed them to properly isolate and abide by public health measures implemented during the pandemic.

"If I was in the shelter system, wow. But just now knowing that I can, like with, during COVID yeah, when you hear them say stay home as much as possible I can and I don't have to have anybody in my place whereas remember in the shelter I was in a room full of five women. this definitely is you know, yeah, like I'm thankful. Very Thankful.

"it means so much because I would have to be in the mass 24 hours per day and I'm not doing that so because I'm in my own place so it's better than that I will with Mainstay."

"I'm, that was just a stroke of luck. That really was. I got in there right at the right time. I will say that. So, yeah, you know I'm not a religious person by any means but God Bless you know."

5.7 Housing Safety

While it was meaningful to have housing during COVID-19, many participants also expressed their concerns about the safety of the building due to excessive drug and alcohol use among tenants. As a result, many participants felt they could not invite their family to visit in these conditions or felt that the building did not provide a peaceful or restful place to live.

"It's a wonderful environment, a wonderful area but the building you know harm reduction I don't use any substances other than tobacco. These stuff keep happening and the environment there are mainly men who have been you know who are definitely using and abusing and so I'm now navigating a lot of."

"It felt like I was tricked because it was perfect and then I started seeing what really went on in here and I had no idea. I probably wouldn't have moved in. [….] You have to crawl over people to get outside of the lobby and persons sitting out like I can't have my grandchildren here; there's a lot of people in here who just do drugs all the time; dealing drugs, slamming doors and they know who they are so I don't know why that's allowed in here."

"It's good. There're cameras everywhere. You got your own key. There's a camera right outside my door. I'm not worried about anybody coming trying to break-in or anything like that.

However, you hear a few nutbars every once in a while, at 3:00 in the morning yelling up and down the hallways but that's to be expected."

The repeated occurrence of deaths within the building also played a major role in participants' sense of safety and well-being concern in the building and among tenants.

"We've had a lot of deaths which is really hard because I've never, I've never experienced so much passing away."

"Yeah, it's basically just you know people come here to die. That's what I actually believe. I don't think many people leave this building and move on so, I've seen 17 people since I've been here die at least."

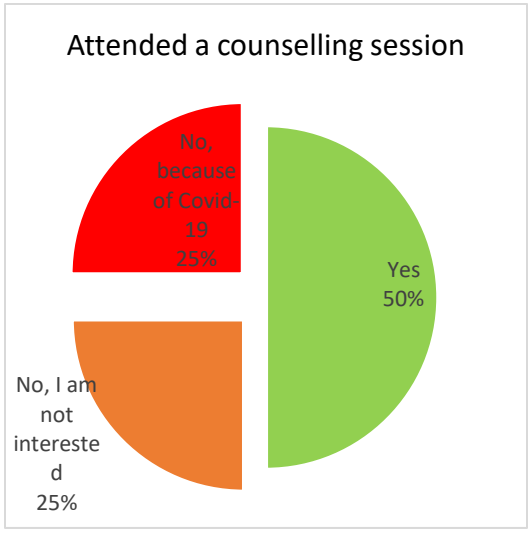
5.8 Program engagement and community activities

As described in the logic model (See Fig 1), the HFG program included a set of programs to encourage and engage tenants in social activities and events within the building and in their community, alongside access to community resources and health care. To assess the implementation of these programs, we asked participants about their level of engagement and community integration over the last 6 months.

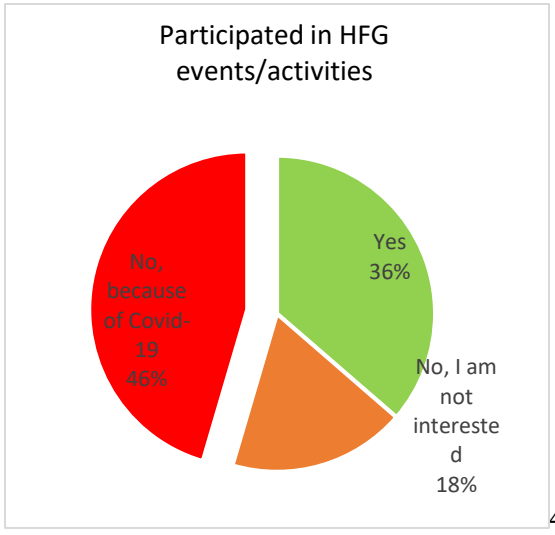
5.8.1 Engagement of the study participants

As shown in Figure 4, 6 out 12 (50%) participants attended counselling sessions over the month prior to their interview; 25% (3) reported they did not attend because of COVID-19, and 25% (3) said they were not interested in such activities. Fewer participants attended social activities or events or volunteering (25%) within the building, mainly because they were not interested or because of COVID-19, 46% and 58%, respectively (figure 4c).

Figure 4. Program engagement during the COVID-19 pandemic



4a



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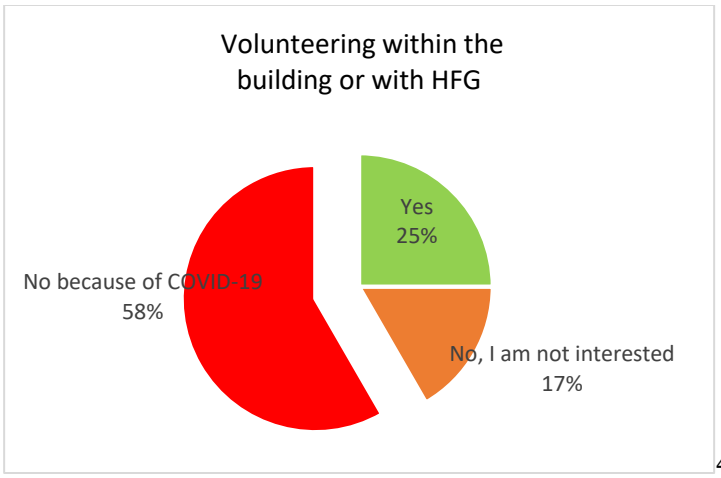


4c

Group activities in the building were put on hold to avoid the spread of COVID-19 during most of the 2020 year, therefore, on-site activities were not an option for new tenants, which made it hard for them to socialize with existing or new tenants and get to know each other. Moreover, some participants reported that they felt less compelled to connect with other tenants or engage in program activities within the building.

> *"These [activities] were non-existent by the time I got in here. People didn't even know I even lived here. People asked me like who I was and I'd been here for two months and by that time you know everything here had been cut for a while like I hadn't heard of the meals."*

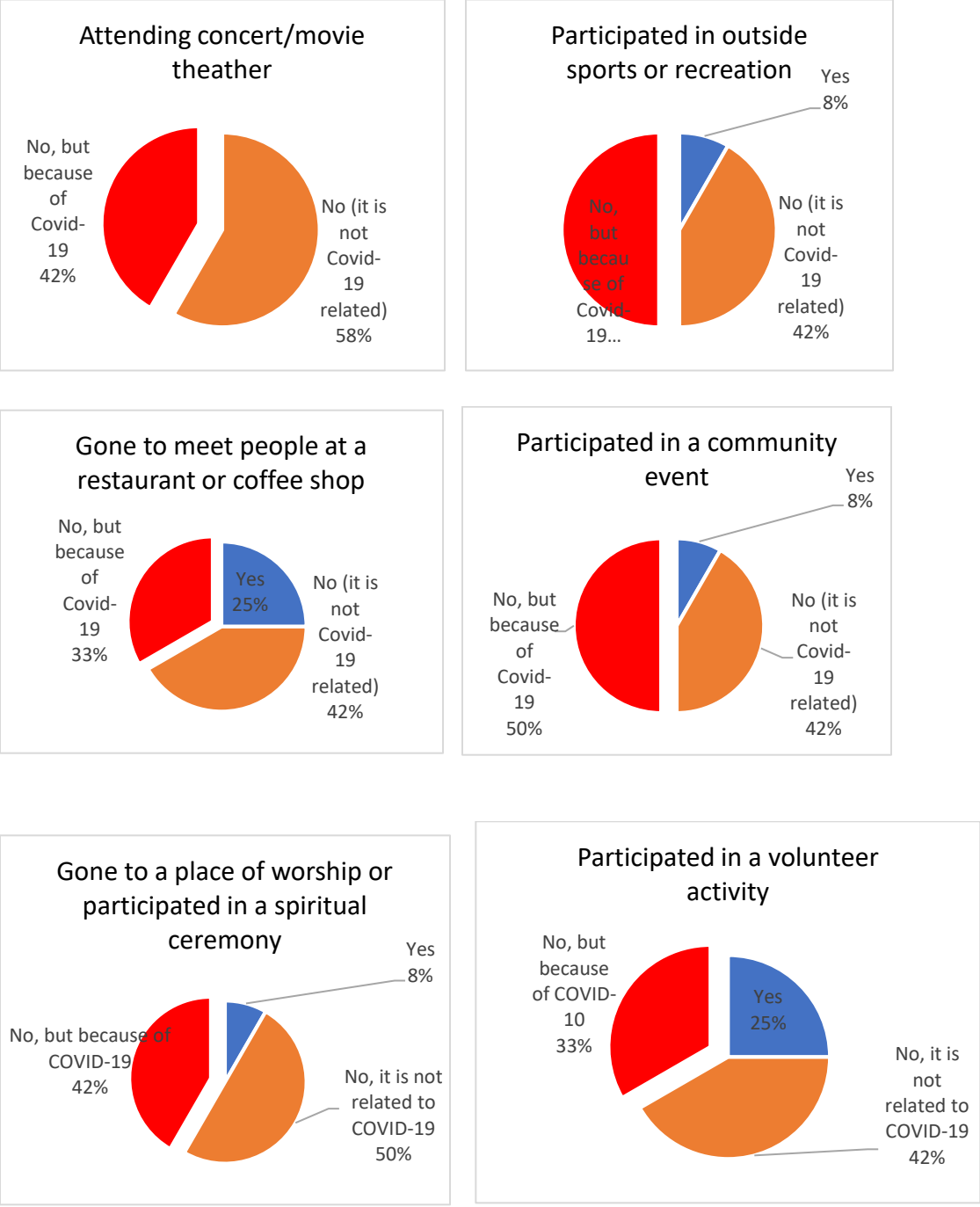
> *"it's just, like I guess I'm anti-social with other people and especially the people that are in a building like this like it's not a normal building where you want to go sit outside and socialize with people"*

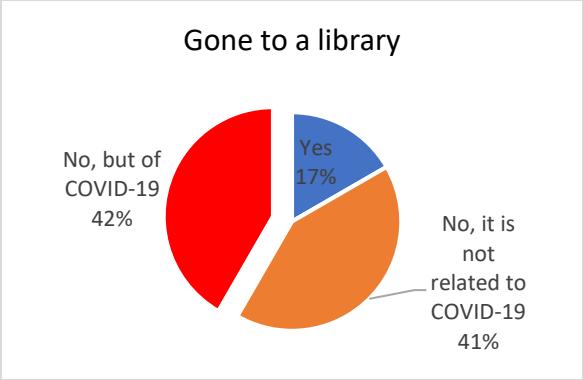
> *"If it was something that I was interested in, yeah, for sure 100% but as of right now I haven't heard of anything that kind of sparked my interest."*

5.8.2 Community resources, activities and integration

Compared to program activities, fewer participants used community resources or participated in community activities during the month prior to their interview. Their level of participation varied from 0% (concert or in movie theater) to 25% (3 out the 12), for activities like meeting someone in a restaurant/coffee shop or engaging in volunteer activities during the month prior to their interview. Many participants reported COVID-19 as the reason why they did not participate in activities. However, others said their lack of participation or use of community resources was before COVID-19 (concert/movie theater or meeting someone in a restaurant/coffee shop/worshiping/volunteer or go to the local library). This illustrates that while the pandemic worsened the situation for many participants, there was already an under-utilization of community resources and a lack of community integration even before the pandemic.

Figure 5. Community resources, activities and integration





During the qualitative interviews, many participants reported the reasons for or how they felt about participating in community activities, including COVID-19 and social distancing measures or having no desire to engage with other residents.

> *"There's nothing open right now. Yeah, with COVID but I'll be the first to get back on the basketball court when it's safe to do so. I still, I got a basketball, two soccer balls, a tennis racket and they're all sitting up in my bachelor apartment."*

> *"It [COVID-19] mean a lot because you know I'd like to get out and meet others and associate with the others and do things together or whatever but because of the pandemic there is not much you can do. You know so it affects your life of what you can do."*

> *"I want to give back to the community because I see actually how helpful the community is to me right now. Actually, I am thankful. Just as I said you know like here's the manager of the building and he's making faces at me like we're friends. -You know it's nice to have that and they've given me a lot. So, just the generosity of people that I haven't seen before when I was in, when I was in the business world."*

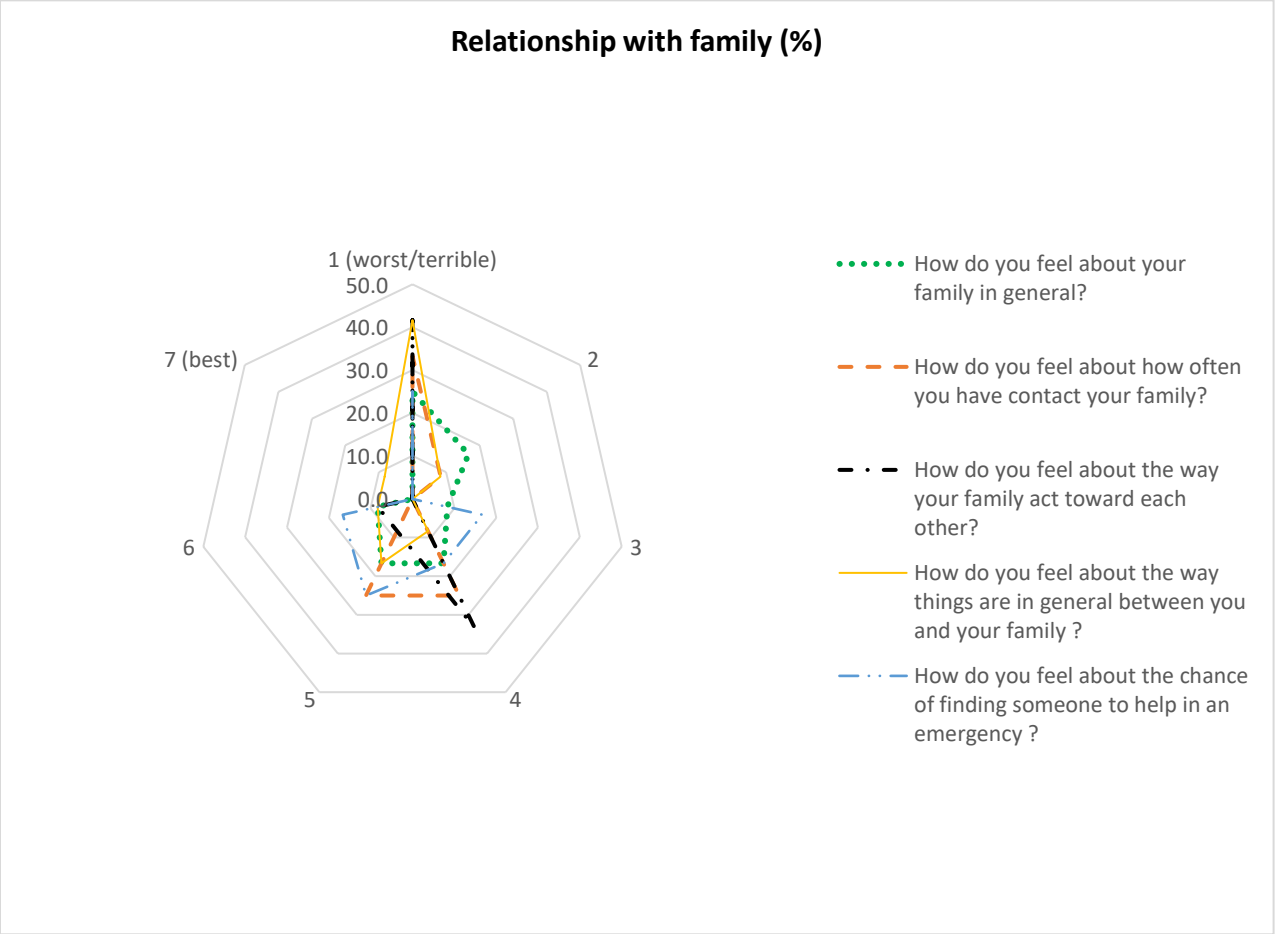
> *"I really have a hard time being a part of anything because mostly it's just people talking about their problems and it's like you got enough problems of your own you don't really want to sit and like I can't empathize with somebody else so I don't belong to any groups or none of that stuff."*

> *"Yeah, it's because of COVID and I don't understand how to kind of get connected to those area [volunteering] that I would like to be at."*

5.9 Social and family network and support

We also identified poor or weak ties with family and friends, or having someone to help in case of an emergency. In the quantitative interviews, we asked participants how they felt about their relationship with their family on a scale 1 to 7, where 1 means worse/terrible relationship and 7, a very good/best relationship. 25% to 43% (3 to 5 out of the 12) graded their relationship as worse/terrible relationship or feeling about the family; while 0 to 2 (0.0% to 16.7%) claimed a good to best relationship or feeling

about their family. The answer was similar when asking about someone they could rely on to help in an emergency.



Many participants talked openly during the qualitative interviews about how they felt disconnected or had difficulties maintaining relationships with family, friends, or other people.

> *"There's none [family] left really. I speak to my sister and her wife on the phone. Besides that, I have a daughter in New Brunswick and just because [Pause] I don't have a full-time job and I can't pay child support and be in my daughter's life full-time right now her mother won't let me talk to her because I went to jail for two years straight."*

> *"Otherwise, you're just laying around in bed waiting to die. If you don't have a social network that's pretty much all you do is you come and go and till one day you have a stroke and you're dead."*

Some participants reported limited interactions with family and a small social circle.

"I don't really have much [social network]. I don't really talk to too many people. I've got one friend that I speak with, well maybe once a week, my brother calls me once a month. My mom died last year. I don't really talk to anybody. I don't have much of a social life at all."

"I haven't talked with my [sister] in five years cause I didn't have a phone and I didn't have any way of getting a hold of her cause I didn't have the resources. Now that I have a permanent address I can write and I can get messages and mail them to her so like it makes me feel more secure in my life now."

Feelings of social isolation increased for many clients during the COVID-19 pandemic.

"I definitely have been a lot more isolated [during the pandemic]. I really interact with less people. Of course, spending more time inside."

"It's [the pandemic time] tough. To be honest with you I'm depressed probably more than anything and I'm not a person who's suicidal or like oh, woe is me. It's just a little bit disheartening that [Pause] just my whole situation. Seeing how I have housing that changed everything and I got my own spot, a safe place to store things, I can own belonging now and not worry about other people stealing them. The independency is great but it's new and I'm not used to not having people around like that"

"I'm basically in my cell you know 23 hours a day well [Pause] sure there's got to be some sort of effect on me, yeah. [….] I used to have like a pretty good social network with the other world out there you know and that's really, really been bothering me like mentally and physically. I haven't been able to connect. It's kind of like I'm just stuck in this building with a bunch of addicts and people with issues which including myself it's just I'm not getting a break with the reality that's out there and that's troubling for me."

"I've noticed now either people, it's bringing out peoples' either worse side or they're just wanting to talk cause they're so isolated and needing to talk and wanting to talk to somebody."

5.10 Health condition, access to care and other supports

5.10.1 Chronic diseases

Among the 12 study participants who answered the survey, only one (8.3%) did not report any chronic physical diseases (CDs), 3 (25.0%) reported one CD and 8 (66.7%) with at least two co-morbidities. The most frequent chronic diseases reported were strongly related with homelessness conditions and poverty like back pain 6 (50%), chronic headaches 5 (41.7%), skin problem 5 (41.7%), dental problems 4 (33.3%) and foot problems 4 (33.3%). Other chronic diseases reported by participants included high blood pressure, lice, scabies or bed bugs infestations, Hepatitis C, arthritis, anemia or bowel conditions among others (See table 6 below)

Figure 6. Chronic diseases

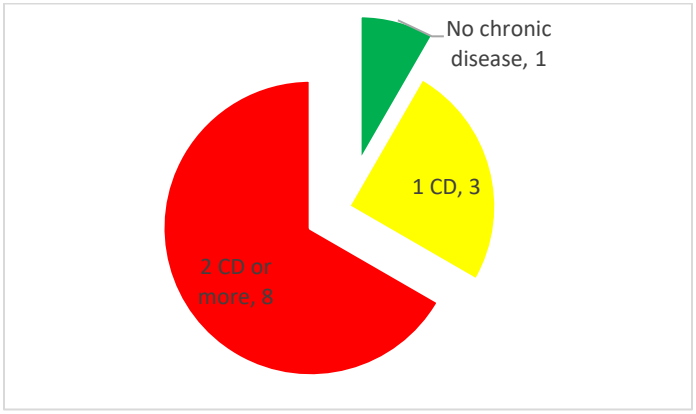


Table 5. Chronic diseases reported by the participants

Chronic conditions	n	%
Back problems	6	50.0
Chronic Headaches	5	41.7
Skin problem	5	41.7
Dental problem	4	33.3
Foot problem	4	33.3
High Blood pressure	3	25.0
Lice, scabies, bed bugs, or similar infestations?	2	16.7
Hepatitis C	2	16.7
Arthritis (joint problems)	2	16.7

Bowel	2	16.7
Urinary incontinence	2	16.7
A Low iron in the blood (anemia)	2	16.7
Diabetes	1	8.3
Ulcer	1	8.3
Lung issues	1	8.3
Ulcer	1	8.3
Liver disease (other than hepatitis	1	8.3

5.10.2 COVID-19 testing

Regarding exposure to COVID-19 and access to COVID-19 testing, only 4 (33.3%) participants reported having some symptoms at the time of the survey. All of them have been tested, and none of them tested positive (Table 7).

Table 6. COVID-19 symptoms and testing (n=12)

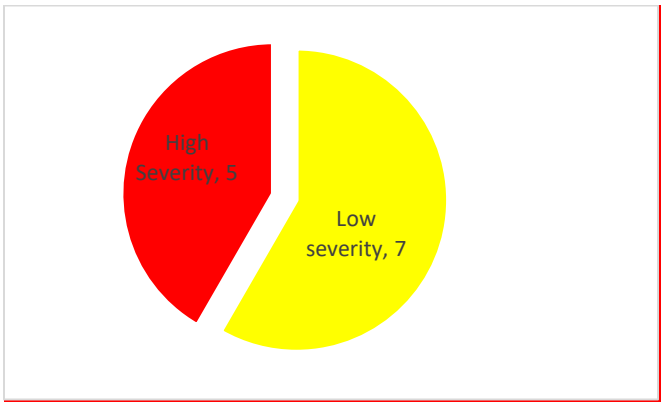
COVID-19	n
Had COVID-19symptoms	4 (33.3%)
Have been tested	4 (33.3%)
Have many time	
1	1
2	2
5	1
Positive cases	0 (0.0%)

5.10.3 Mental health screening: Colorado Symptom index

We used the Colorado Symptom Index[2], a validated and largely used index to assess psychological symptom severity with a self-report measure of psychological symptoms. The main finding was that all participants showed some level of mental health problems, and 5 (41.7%) were suffering a high level of mental health problem severity (Fig. 7).

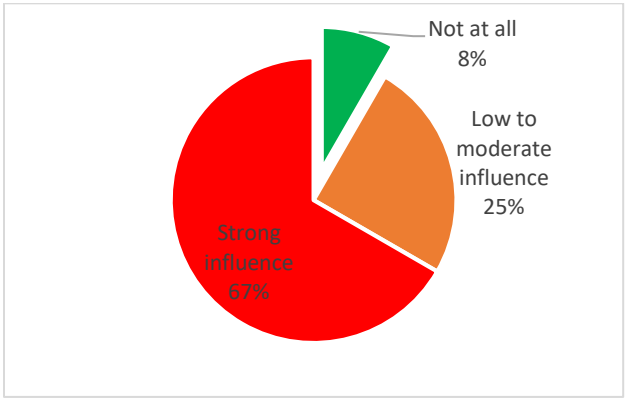
[2] The index includes a list of 14 questions, asking the participants to grade some mental health problems or issues that their might have had in the past month, such as: "In the past month, how often have you felt depressed?" or "In the past month, how often did you feel suspicious or paranoid?". The answers can be, "not at all", "Once during the month", "several times during the month", "Several times a week", "At least every day". We used that 30 is the cut-off score to qualify High severity (>30). For more information on the CSI and the cut-off score, please see: Roger Boothroyd and Huey Jen Chen (2008). The Psychometric Properties of the Colorado Symptom Index. *Administration and Policy in Mental Health and Mental Health Services Research* 35(5):370-8

Figure 7. Mental health: Colorado Symptoms Index



We asked participants to what extent they perceived that the COVID-19 pandemic affected their mental health in general. Almost all participants (11 out of 12) reported that COVID-19 worsened or deteriorated their mental health conditions, and 8 (67%) said that the negative influence of COVID-19 was very strong.

Figure 8. COVID-19 worsened or deteriorated your mental health conditions



5.10.4 Alcohol and drug use

We also screened for the severity of alcohol and drug use using the Global Assessment of Individual Needs – Short Screener (GAIN-SS)[3]. Among all participants, 5 (41.7%) presented moderate alcohol or

[3] The index includes a list of 5 questions, such as "how often you used alcohol or other drugs weekly or more often?" or "When was the last time that you kept using alcohol or drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?" The answers can be, "Past month", "2-12 month ago", "1 or more years ago", "Never", "Don't know/Decline". First, we scored the answers into "1" if the answers were "Past month" or "2-12 month", and "0" otherwise. Then, for each participant, we calculated a total score by adding the scores. The total score ranges from 0 to 4. We used a total score of "0" to qualify "No alcohol or drug problem", 1 or 2, a moderate alcohol problem, and 3 or 4 a severe alcohol problem. Please see: Dell and Sprong (2016). Test Review: Global Appraisal of Individual Needs–Short Screener (GAIN-SS). Rehabilitation Counselling Bulletin, 60(2): 121-124

drug use issue, and another 5 (41.7%) presented severe alcohol or drug use issue. It is worth noting there was a significant number of participants who reported starting their alcohol and drug use in their childhood. In fact, among 10 participants with some level of alcohol or drug issue, 6 got drunk before 18 years old, and 7 used drugs for the first time before 18 years old.

Figure 9. Alcohol and drug use (GAIN-Short Screener)

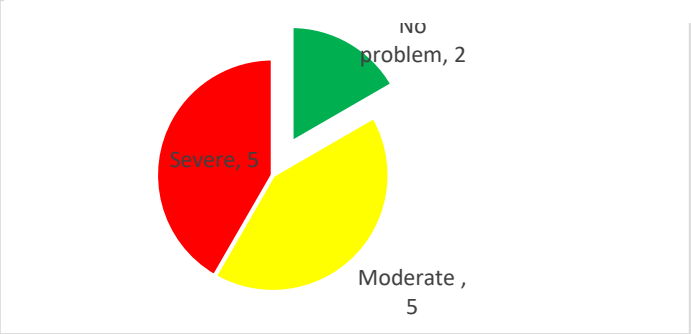


Table 7. First drunk and age at first

Age	Age at first got drunk	Age for the first drug use
<18	6	7
>=18	4	3

5.10.5 Acute health use and justice involvement

We also asked participants about their use of acute health services over the 6 months prior to the survey. Out of 12 participants, 1 had used ambulatory services, 3 had visited a hospital (by themselves), and 5 visited the emergency department (ED). Among those who used the ED, 1 had 3 ED visits and another had 5 visits.

Table 8. health Care utilization over the last 6 months

Services	n=12	%
Hospital visit	3	25.0
ER*	5	41.7
Ambulatory service	1	8.3
Approximately how many emergency room visits did you have in total?		
1	3	
3	1	
4	1	

Regarding contact with the justice system, 5 (41.7%) participants reported contact with police over the 6 months prior to their interviews. However, only 1 has been arrested and was placed in a police cell, and none had spent more than one night in jail. We also found 2 cases of court appearances over the 6 months prior to their interviews.

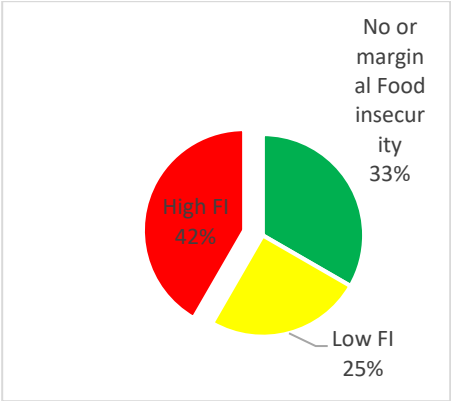
Table 9. Justice involvement over the last 6 months

Justice involvement	n=12	%
Contact with police	5	41.7
Have been arrested	1	8.3
Have been in police cell	1	8.3
Had any court appearances	2	16.7
Jail for more than on night	0	0.0

5.11 Food insecurity

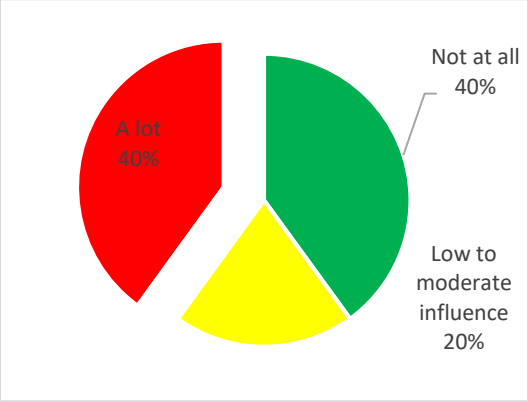
Furthermore, we used a food insecurity (FI) index to measure the level of food insecurity reported by participants. We used the 10-items U.S. Adult Food Security Survey Module, which is validated and largely used in previous studies with individuals with homelessness experiences[4]. The food status of participants was classified into four categories, very low FI, marginal FI, low FI, and high FI. Out of 12 participants, 4 (25%) showed a low level of FI, and 5 (42%) had a high or severe FI, while only 3 (33%) showed a very low or marginal FI level. As expected, 40% of participants reported that COVID-19 worsened or deteriorated their FI status. We also explored partipants' access to food within the buiding , as well as access to food through external programs and services.

Figure 10. Food insecurity



[44] https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/survey-tools/#adult
Lachaud et al., (2021). Severe Psychopathology and Substance Disorder modify association between Housing Trajectories and Food Security among Homeless Adults Participating in the At Home/Chez Soi Study. *Frontiers in Nutrition*. https://doi.org/10.3389/fnut.2021.608811

Figure 11. COVID-19 worsened or deteriorated your general food security status



Many participants had used drop-ins, community meal centres, or meal programs 5 (41.7%) or food banks 9 (75%) over the last 6 months.

Table 10. Used drop-in/community meal centres or Food bank over the last 6 months

Services	n=12	%
Drop-in, community meal centres, or meal programs	5	41.7
Food Bank Use	9	75.0

5.12 Quality of Life

Finally, to measure participants' sense of well-being, we asked on a scale from 1 to 7, how do feel about your life overall over during the last 6 months. This question was from the Quality of Life interview 20 (QLI-20)[5], which has been widely used and validated in previous housing studies to measure quality of life[6] . The answers were classified as a bad quality of life (1), a moderate quality of life (2 or 3), and a fair to good quality of life (5 to 7). Only 2 (17%) out of 12 participants reported they have a fair to good quality of life; while 7 (58%) reported a moderate quality of life, and 3 (25%) reported a bad quality of life. When asked to what extent COVID-19 worsened or deteriorated their quality of life, half of all participants reported that the pandemic worsened or deteriorated their quality of life; almost one-third said it had a low to moderate influence on their quality of life.

[5] Lehman AF. (1996) Measures of quality of life among persons with severe and persistent mental disorders. Soc Psychiatry Psychiatr Epidemiol. 31:78–88.

[6] Thomas Uttaro and Anthony Lehman (1999). Graded response modeling of the Quality of Life Interview, Evaluation and Program Planning. 22(1):41-52

Figure 12. How do you feel about you life overall

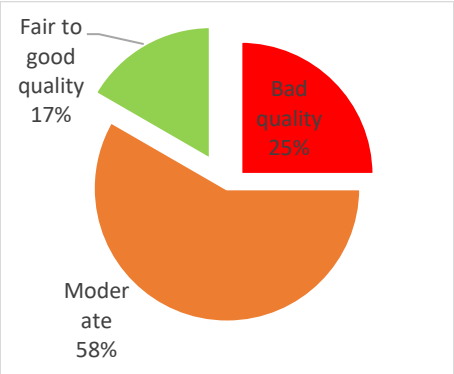
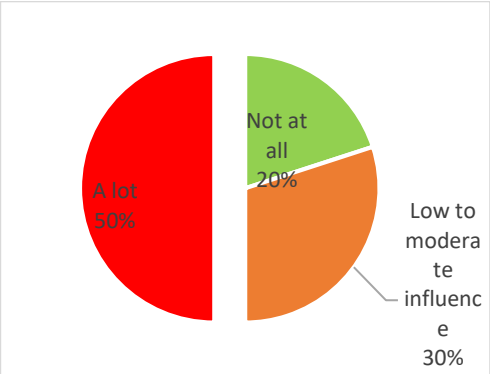


Figure 13. COVID-19 worsened or deteriorated how you fell about your life overall



5.13 Mapping social and health supportive services

During the qualitative interviews, participants showed mixed feelings about the support services offered by the program and their interactions with staff and housing workers. Many participants found that health care and health services were available whenever they needed to access them. They also mentioned that if they needed someone to accompany them, their housing support worker through Mainstay would assist them with this, making them feel supported.

> *"it's available and it's been offered so I do have access to that through my worker here."*

> *"I go to the doctor whenever I need and if I want someone to come with me, if it all depends on how I feel and if I want my supportive worker to help me to go there, they try and come to help me"*

> *"I already got the one shot. I guess a couple of months from now I get another one and I'm COVID-free for life. And that's thanks to Mainstay cause I didn't even know about these shots; I knew about them from the media and stuff but I just didn't research them and I didn't know about it."*

Other participants expressed that they wanted to use certain health care services but were unsure or unable to get in contact with a health care provider. Difficulties with renewing their health card was also a barrier to accessing health care.

> *"I don't have any information for to do it over the Internet or anything like that. I have Internet so I can contact people over the Internet but I don't have any contact information for who to contact or what to do"*

> *"I've been having some issues with mental health lately and I'm just worried I'm going to end up just sitting and waiting to die and then it's just depressing so and I wouldn't mind some help."*

"I don't really have access to those since I come here because obviously the COVID, my health card is up today when I reach end of term of March. But last year and I don't understand how to go through the system to get it."

With the shift to the online provision of health care services during COVID-19, participants had mixed experiences with the new platform. Some found it much more convenient to access health care online, while others had difficulty understanding [navigating] technology and had challenges accessing health care as a result.

"Because I would cancel appointments just because of my pain level and stuff like that. So, this definitely is convenient cause I can make my appointments now."

"I don't have technology and I don't understand technology I see it and I watch it and I, well because I don't have, I don't understand it."

5.14 Interactions with housing, caseworkers or other staff

There were mixed levels of involvement among participants regarding their interactions and relationship with Mainstay staff. Some participants felt comfortable with their worker and thought they were good, nice, and supportive.

"He [participant's worker] actually cares, you can tell he's genuine. They get a lot of donations here and he's the type of guy who thinks about you. He'll see the stuff come in and comes and gets me and makes sure even if I'm having a bad day and I'm kind of down and I don't want to go out of the apartment or I just want to do my own thing, he'll say there's good food down there and he'll say come down and it's all good stuff."

"he always checks up on me and he's polite about it; he's not pushy. He's always genuinely concerned and that doesn't bother me cause I don't have much family left, a lot of friends like I said. He doesn't know me very well and I'm not a part of his social gathering. I'm just under his caseload but he really cares and that means a lot to me."

Another participant reported that they tended to deal with problems on their own and were not comfortable with opening up to their worker.

"I'm not working with anybody. I'm just kind of, I'm just kind of well I'm looking out for number one with myself you know I'm not really one to, I don't know it's just my mentality just to pour on my problems. I tend to get a little stubborn thinking oh, if I can't fix it and all that you know but you know I haven't really opened up with my worker"

Some participants expressed feeling disconnected from their worker. Reasons for this included some workers being inaccessible or not checking in on participants. These sentiments were exacerbated by COVID-19. Overall, participants hoped for more interaction.

"he's never around and he just kind of brushes you off and all the other workers, most of them the female ones here really go out of their way for me and I don't really ask. They just know cause they know this is what I'm going through too; right. And they volunteered a lot of stuff that I didn't even know that was out there for me that my worker didn't and I don't know it's just, there's just no connection and that's, that's a human condition sometimes; right."

"I don't know. I just talk to that one person when I came here and then I've never talked to anybody since. , from Mainstay they gave me R and then I haven't had anybody else since. Nobody tries to call me or write me letters or nothing"

"I really would like you to make a note if someone you know maybe just saying hi to N once a day. Would it kill a worker to just knock on the door and say hi? That's all it would take with him or if he's outside just say hi, how are you doing you know like that's all it takes sometimes. That would be nicer to see. I just don't want him to die next. It'll probably be me but you know what I mean and that's it."

6 Living more independently: Participants from the Move-On group

We also conducted interviews with 10 participants who moved into the private housing market. Most were men (9 out of 10) with average age 45.6 years. The youngest participant was 29 years old and the oldest one, 69 years old. During the interviews, they were asked about their experience with the process of searching and finding housing in the private market, their new environment, social relationship and life after their move as well as their hopes and plans for the future.

Figure 14. Self-identified gender of the participants in the Move-On group

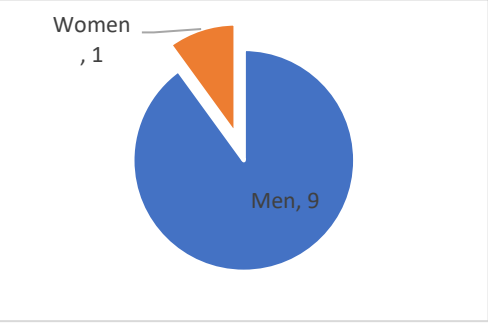


Table 11. Age of the participants in the Move-On group

Age (n=10)	
Age average	45.6
Std. Deviation	13.2
Age min	29
Age max	69

6.1 Searching and finding housing in the private market: a long and draining experience

Participants experienced many obstacles with the process of finding and applying for private market housing. They noted that searching and applying for housing on their own was draining. Many of their

applications were rejected; however, the support and accompaniment of the housing workers were crucial to the process. Financial assistance was provided by Mainstay Housing to cover the security deposit payment, and their involvement in negotiations with the property owners also played a significant role in the process.

> *"I think in 2019 for sure I was looking for, actively out you know doing my own search in the private market for housing and it was kind of draining and a little bit [Pause] whatever disappointing cause I'd have to hustle, hustle, hustle to get to places you know. If there was a vacancy, I had to hustle information to them--and my, you know my applications were rejected. I think when they saw how many sources of income I have because I have multiple sources of income."*

> *"I participated to two or three lotteries for Toronto Housing and yeah, I didn't get it. it was through my caseworker. It was through my housing worker that I found, my housing worker found it. It's very hard so she helped me with the process and then she found this place that I'm at right now."*

> *"I've had a couple of housing workers at the time so right now she's not Mainstay so, O is my worker. So, at the time when she was my worker me and her got this place and then you know we signed the agreement and then I think we paid like a security deposit but Mainstay paid the security deposit so after that like within like a couple of weeks I moved in"*

> *"I had a lot of help from my supportive housing worker, a very nice lady with Mainstay. She kind of wound up filling in for the housing locator so it, for me, it was really quite stressful because Mainstay like in the last two years they've had three housing locators so I met the first one and she left after you know I don't know two months, two or three months"*

Some participants reported a lack of support from their housing workers or high staff turnover which delayed the housing relocation process.

> *"I was put on the list for HFG and it was a complete circus. They basically gave us two months to find a place in the winter. The housing worker, she basically told me good luck finding a place, there's nothing in winter and then she went on holiday for two weeks so nothing came of it. I was very upset"*

> *"it actually took a long time because the workers were changing so it didn't it took a lot longer than I expected"*

Most participants reported that their housing choice mattered and was valued by their housing worker. Below, we report a quote from one participant to illustrate the process:

> *"I had to choose it. We [with the housing worker] were working together to see what options are on the market- because market dictates where you're going to go. whatever was available at this point and I pick and choose; mine was final say in it. I worked with the ODSP and all my financial things I put together- to make sure that I can actually financially be on my own and then when everything, those things work out, it's those basic things, took probably six months to*

figure out those numbers and then after that I was ready to be, probably two months to [Pause] go from Point A, Mainstay Building to where I am now."

7.2 Being happy, safe and secure in their new home

Overall, participants were happy with their private market housing and felt it was safe, comfortable and quiet. Having a good relationship with their neighbors provided them with a sense of security. Meanwhile the cleanliness of the building, having natural light in the apartment and the overall spaciousness of their new housing made them feel comfortable, healthier and relaxed.

"Oh, my God like I was just this is a totally different world all together for me like I, like I said I'm safe, I'm comfortable, it's quiet. [Pause] It's close to all of the amenities. It's everything I could ask for. It's clean, it's safe. [Pause] There's a lot of people in this building that are handicapped and nobody's going to hurt anybody here you know."

"the apartment is, it's beautiful, it's large, it has a bedroom which I didn't have at the other place. It's very bright. It's an apartment above stores. It's a small strip of stores with apartments above it so I have a very long front window facing east."

They also felt more independent and able to reconnect with family and friends.

"It's way better than used to be because less problems and no headaches and so I'm able to live on my own -and make my own decisions; right. I have no known hard mental issues. Well, things were there (Referring to Mainstay support services) throughout but we had more help down there so I am more independent now."

"I got more freedom in ways like I can go live somewhere else where I want to be. I don't have to be, because I lived at [address removed] for ten years and the thing was I couldn't go anywhere else. I couldn't move anywhere else where I wanted to be like I technically want to move to [place 1 removed] or [place 2 removed] because my family is up there. It's a lot easier but you know this got me a little bit closer now to live closer to my family."

6.2 My first 2 weeks in my new place: Hesitant and strange

Most participants found the initial change of environment quite stressful and challenging. After living at the Mainstay Housing building for so long, the transition to a private market house required some adjustment or adaptation time.

"It was strange and it took me quite some time to get used to the change. I don't really deal with change that well. And it's kind of been like I loved the quietness here. It's, compared to like I say it's a very different world here. This has been pretty good. We've had a couple of bad neighbours which I can get into after but one of them has moved out so that's good. But I mean day-to-day living it's fine. I'm able to take care of myself within my home so it was nice, it was wonderful to have a bedroom."

"when I first moved here, I had a back spasm and it was horrible. My back was so locked up because of the stress and it's not because of this place, it's because you know what I just moved for ten years of being somewhere. That's a big jump; right, but now I can move better because I'm more relaxed; right. After I had that spasm I honestly, I could start lifting, that heavy stuff again because my back is more relaxed. Right, my back when I first came here it was so solid."

One participant reported a negative impact like more social isolation and deterioration in their mental health status. It is important to mention that this participant moved in during the pandemic period, when many public health measures and physical distancing were imposed.

"I was exhausted after I moved in here and because it was very stressful you know I, you know it affected my health so last year I started having you know health problems that I haven't experienced you know like I had physical problems and some, you know, I think also a bit of a regression in terms of some mental health problems and also I was much further away or more isolated from any support because of first of all the pandemic so you know it wasn't encouraged to have workers come here of course."

6.3 Social relationships, technology, and COVID-19 in the new home

Another important change that accompanies moving into the private housing market is forming new social connections and potentially losing old ones. We asked participants about significant changes to their social relationships and community interactions after their shift to private market housing, and we also inquired about the impact of the pandemic on their social connections.

There were significant changes to participants' social networks after moving into private market housing. Some participants experienced positive changes in their social networks, specifically opportunities to reconnect with their family.

"Yes, honestly, my family has seen me do a 360 on my attitude, I'm not stressed out about it anymore cause I'm not walking on eggshells, I'm not walking, I'm not worried, like I'm getting sleep now that I didn't have because I was getting bitten by bedbugs that I'm allergic to"

"Well like I'm kind of like a bit of an anti-social as is but like me moving into this place and stuff I am talking to my neighbors, I am like I have roommates now and my roommates we all communicate."

Other participants missed being able to interact with people how it used to be at the Mainstay Housing building.

"(Mainstay building) It was very good you know it was very good because you get to talk to people. You need that interaction so like now it's different but before it was, you know I had that social network."

"As far as family and friends go again, like it was interesting the move. Although I was happy to get out of the building, I kind of suffered with the depression because I lost the connectivity I had with, you know, other neighbors in the neighborhood where I'd lived for a long time."

Due to restrictions imposed as a result of the pandemic, some participants were unable to connect with friends and family, meet new people, or build new supportive connections. However, they also felt some comfort in their new home.

"The lockdowns and the pandemic thing it's been really hard to meet any new people and to build any new supports."

"I can't see my friends so it's just kind of hard on, it's sort of hard on the relationships that not being able to see my friends all the time."

"I'm perfectly happy just sitting here watching my big screen TV and I prefer that now that I'm old; right I just, I'm not able [to see my family]."

During the pandemic, some participants used technology to stay in contact with friends and family.

"Now technologies are advanced that you can Zoom with anyone, you can go to workshop, you can call, video calling so things are easy."
However, others found the shift to online social platforms uncomfortable.

"I feel kind of uncomfortable with things like Facebook and I'm more of a face-to-face type of person."

6.4 Access to basic needs

We sought to understand how new financial restrictions after moving into the private housing market might have impacted participants' access to food and food insecurity. Participants reported mixed experiences with access to food. Some participants were able to maintain a balanced diet, consisting of fruits, vegetables, and meat.

"It's not too much of a difference like I go grocery shopping like twice a month. I normally do is like I will get my fruits and vegetables, my frozen foods, my meats and it's not much of a difference in the neighborhood kind of thing. It's a little bit further from the grocery store from my house but it's just one of those things."

Other participants struggled to access food without meal and food supports from the system.

" The other aspect of moving here has been that the support I used to have in terms of meal support and food support from the system has disappeared. The cost of food has gone up considerably during you know"

"Well, no [access buy enough food], I you see that? I did have enough funds but you see all my income goes to a Trustee's Office"

"I got on special, thank God I got on special diet and [Pause] a few other things and I get pretty much almost a grand a month on top of my rent and I was happy for a while. I was like okay, I'm filling my fridge more now [Pause] kind of thing and then all of a sudden, this pandemic has been really raising the prices and it just seems like it's not, it's not really made a difference now with that extra income."

Food banks were more difficult to access for participants who had moved into private market housing. With no food banks being located nearby, some participants had to rely on public transportation to get to food programs. As a result, they utilized food banks much less due to the cost of using public transportation. It seemed also that some food banks have restrictions depending on how much some participants earned on ODSP.

"I went to the food bank near downtown because there is no food bank near me close. I would have to take the bus; right, so that's why I went downtown, yeah, so I'm still part of the food bank but I try not to do it as much"

"I would get a drive from my sister to go grocery shopping when I get paid but food banks wise the last time, I used one they said I can't use them anymore because of how much I earn on ODSP."

6.5 Wellbeing, hope, and plan for the future

After moving into private market housing, many participants had hopes for a brighter future. Having their own place allowed them to shift their focus to tomorrow and plan for their future.

"I'm, I can now focus on like normal shit. Now the future is a little bit brighter like yeah, I had a place but it was just like a small-ass apartment."

"Just makes me feel whole like I'm actually, you know, on the right path. Beginning steps. The right steps"

Moving forward, some participants hoped for a career, economic stability, and home ownership. They were also hopeful for future opportunities so that they could become financially stable and be able to better support themselves and their family.

"my hopes is that this career that I chose cause it is a career will turn out to be that; right, and that it will set me in place for opportunities for myself and others cause I have a daughter. I have a daughter so yeah, I hope that all of that I've, all the work that I've put into this job I'm hoping that it turns around financially and I can buy my own house and I own my own house."

"I want to have a place where I can stay there till, I die. I don't want to move around anymore"

However, for others, planning for the future was still difficult, unpredictable and unstable.

"Those are not easy to answer questions because in the Canada there is nothing for granted. You are okay or not okay simple as that. Employed, you are not employed. Anything can change at any time "

"I still don't have sense of stability because this place is going to be gone eventually."

7 Participants from the In-Transition group

We also conducted qualitative interviews with 10 tenants who were on a waiting list to move out or expressed their desire to move out from the Mainstay Housing building into the private housing market. They were mostly men (8 out of 10) and on average 51 years old. The sections below discuss the results from the interviews.

Figure 15. Self-identified gender of the participants in the In-Transtion group

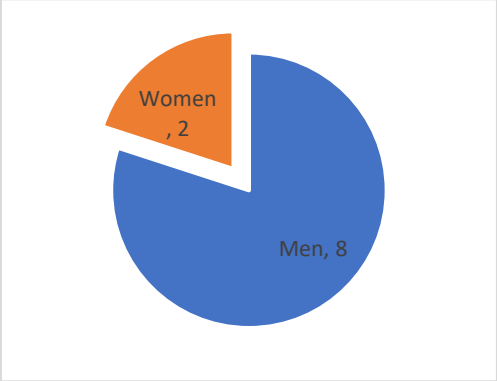


Table 12. Age of the participants in the In-Transtion group

Age average	51.0
Std. Deviation	9.5
Age min	35
Age max	61

7.1 Living in the program building

Most participants have been living in the Mainstay Housing building for more than 5 to 10 years. Some expressed interest in becoming more independent. Many others complained that the situation in the building had deteriorated, and cited multiple reasons for wanting to move out including issues with bedbugs, safety, the occurrence of death of tenants, and alcohol and drug-related issues faced by other tenants.

> *"I was in a shelter and I was having some health issues…**Two years later they schedule for a back surgery. They told me I cannot move a step for a while**. I needed a place where there is an elevator or street floor because I cannot go up and down the stairs. That is when I moved to this building more than 10 years ago."*

> *"I moved in here 15 years ago, yeah, it's been nothing but nonsense since. I've seen so many people die and you know like I got to get out of here before I die myself."*

7.2 Moving out: why do you want to leave?

Over time, many of these long-term tenants found the building has been deteriorated, with many safety and cleanliness issues that have not been addressed by the management. Some participants complained about nuisance and health hazard due to bedbug or other infestations. They also reported the frequent occurrence of deaths in the building among the main reasons for wanting to move out. Other also talked about feeling unsafe because of circulation and selling of illicit drugs within the building. Participants expressed frustration with these issues, which seemed to increase amidst the pandemic.

> *"I want to live somewhere but I want to live somewhere on my own. I don't want to be in a building like this with a shitload of people that got [drug addiction] issues and problems…everybody wants to know what the hell you're doing. And it's very frustrating and with the COVID thing going on it intensifies"*

"One year it's fruit flies. The next year it's all mice, the next year it's all the bedbugs. It's just, this building is, I don't care how much you try and do. They put new laminate down and baseboards and new this, new that. They're already in the walls. They're already in the building. You ain't getting rid of them."

"Every time I walk outside there's an ambulance or a fire truck or you know like I've gotten to the point where I'm looking at officers and fire and ambulance you know like on a first-name basis."
"I moved in here 15 years ago, yeah, it's been nothing but nonsense since. I've seen so many people die and you know like I got to get out of here before I die myself."

"At first it was not bad. It was a lot better than where I was pin shelters] but then it started getting jut a low worse anyway but yeah, at first it was great."

7.3 Obstacles and barriers: A long and frustrated wait

While participants expressed their desire to move into the private housing market, they faced many obstacles and requirements including not have government identification, credit score, proof of stable income, and social status discrimination and stigmatization for receiving social assistance. Moving out of supportive housing to the private housing market can be a very long process that can take years and, many times, discourages and frustrates participants. As reported by one participant:

"I really want to move to a one-bedroom apartment; the only reason is because I have two daughters…but they cannot visiting me because they cannot stay here…another worker who come here, he says me, I not going to be approved so don't even bother to apply." [A20]
Other participants reported:

"I am on a few lists for new units; right, like there is condominiums they're putting up or like a year for you know that she has me on but she's telling me that these things can take like you know two to three years to be able to get on them"

"a lot of people don't want to take somebody on ODSP. They think you got an issue and a problem; they don't trust you; you're not going to give them their money."

Many participants expressed their preference to move into a one-bedroom apartment to have more space and, ideally be near public transport.

"My ideal apartment would be a one-bedroom or a bachelor with a balcony in this area or you know what I believe I can adjust to just about any area because I'm not a picky person you know as long as I, you know have TTC, convenient for the TTC."

7.4 Move out and what? Plan and hope

Beyond moving out, many participants talked about their future plans regarding employment and educational opportunities, as they felt that that would allow them to become more independent financially and in everyday life.

> *"I want to at least you know get back that independence you know that you know working for my own money you know basically I work for it; I can spend it how I spend it; with OW you're sort of limited. I'm limited to you know what I can purchase you know and it's a scary thing to know, you know, they can come to me one day and say okay, I'm sorry we're going to have to cut it off"*

Participants also hoped to reconnect and maintain healthy relationships with their family. Part of that included moving into a safer building where they felt more comfortable bringing their family to visit.

> *"like I said first to move my first thing would be able to see more of my kids. Well still I can take care of myself you know like I don't care if somebody attack me for something or whatever you know I going to fight to death if I have to but--I don't want that--for them. I don't want to, they come here, they only come once--and I didn't feel comfortable."*

8 Key findings and lessons learned

This section of the report presents key findings from the evaluation and lessons learned that can help inform the development and implementation of future programs in the social and supportive housing sector.

The COVID-19 pandemic: Re-Engineering supportive HGF program

The re-engineering of HFG supportive services during the COVID-19 program was necessary for the protection of health and prevention of COVID-19 outbreaks. All in-person activities were put on hold in accordance with public health guidelines in the building during of the study. Additionally, many other measures were implemented including facilitating food access to tenants, distribution of a phone to reduce social isolation and facilitate virtual program delivery, renovation in the building to resume counselling activities and provide areas for housing and peer-workers to meet while adhering to physical distancing protocols.

However, we also found these measures had some limitations and unexpected outcome for tenants. First, the program only enrolled and housed (Move-In component) 32 of the initial target of 60 individuals, from whom they registered two cases of evictions and one death; and the Move-On component, which supports previous long-term tenants who wanted to move into private housing market, reached approximately half (20) of the targeted group. Moreover, the Move-On component was put on hold, then defunded due to shifts in the program's priorities. Tenants of the HFG program also became more and more socially isolated, their mental health deteriorated, and increase alcohol and drug use was reported. Finally, there was high rate of turnover of housing and peer-workers, who complained about staff burnout during the pandemic.

Homelessness history and rehousing

The homeless histories of program clients are also diverse, with a third of participants reporting their first experience of homelessness before they turned 18 years old, while some had their first experience at 50+ years old. Some participants reported moving from shelter to shelter, while others alternated between couch surfing, staying in shelters or on the street, and jail. Overall, the time spent homeless varied greatly from less than 2 years to 30 years.

In general, participants felt thankful and safe to have their own apartment and to regain some level of *privacy.* They also expressed that having their own place allowed them to properly isolate and abide by public health measures implemented during the pandemic. However, some participants raised concerns about safety due to drug activity of other tenants, lack of cleanliness and pest infestations, and repeated occurrences of death within the building.

Program engagement, social activities and isolation

The findings showed that program engagement and participation in community activities among participants varied. Only half of participants reported attending counselling sessions in the month prior to their interview. Few attended social activities or events (25%) or participated in volunteer opportunities (25%) within the building. The proportion was even fewer for the utilization of community resources or participation in community activities, from 0% attending concerts or movie theaters to 25% (3 out the 12) in activities like meeting someone in a restaurant/coffee shop or volunteer activities during the month prior to their interview. Though many reported COVID-19 as the cause of not engaging or participating in such activities, a large proportion, approximately 17% to 58%, did not participate in these activities even before the pandemic. Some participants expressed a lack of interest in the type of activities offered by the program.

Furthermore, lack of family and social networks remained an important issue. Only two (out of 12) reported having a good to best relationship or feeling about their family. In the qualitative interview, we found that participants reported poor or weak social networks. Social isolation increased during the pandemic and many reported feeling alone, depressed, and anxious.

Beyond rehousing: other unmet needs

Beyond rehousing, we found that participants had other basic unmet needs. Many reported chronic health conditions that are linked to homelessness and poverty including back problems, chronic headaches, skin problems, dental problems, foot problems, high blood pressure, Arthritis (joint problems), and low iron in the blood (anemia). A total of 5 (41.7%) participants showed severe symptoms of mental health problems, 5 (41.7%) had a moderate alcohol and drug score and 5 (41.7%) a severe alcohol and drug score. More than half of participants experienced being drunk and drug use before age of 18 years old. Participants were living in deep poverty, with a monthly payment from ODSP or OW with an income 30% and 56.1%, respectively, lower than the Ontario's poverty line of $20,057 per year for a single person in 2020. Moreover, 5 (41.7%) participants had a severe food insecurity score, despite 9 (75%) reporting that they were using food banks.

Private housing market

Findings showed that many requirements and obstacles hindered participants from moving to private market housing, including not having government identification, credit score, proof of stable income, guarantor, social status discrimination and stigmatization for receiving social assistance. Searching and applying for housing in the private market can be a long and frustrating process, and support from housing workers and the program management staff as guarantor were crucial. However, participants who moved were happy with their private market housing, felt comfortable, safe and more independent. Although many needs remained unmet, including social isolation and food access, they were hopeful for the future financial security and reconnection with their family.

Interactions with housing and peer-workers

Finally, these findings revealed that participants had mixed feelings regarding the support services offered through the program and their interactions with staff and housing workers. Many study participants found their housing worker very supportive and available when they needed support; while other participants expressed feeling disconnected from their worker. They felt some workers were inaccessible or not checking in on participants. These sentiments were exacerbated by COVID-19 restrictions.

Some recommendations are given in the Executive Summary section, which are not repeated here.

9 References

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10 Annexe: Table of Key Indicators

Domain	**Key outcomes**	**Instruments/Source**
Socio-demographic variables	Socio-demographic information will be collected on: age, gender, race, and country of birth, education	See Questionnaire in Appendix B1

	level, residential history (first homelessness experience/homeless episodes/duration of homelessness during their lifetime and 1 year prior to program enrolment).	
Housing stability	Days in stable housing over the last 3 months (number and percentage) Housing incidents/eviction	Standardized Modified Residential Time-Line Follow-Back Calendar (RTLFB) /Survey Mainstay Tenant Management Information System (TMIS): module notices and Evictions)/ Administrative data linkage
Chronic Disease	Self-reported data	Survey (see questionnaire)
COVID-19 symptoms and diagnosis	Self-reported data	Survey (see questionnaire)
Life quality dimensions	Quality of Life Index 20 item (QoLI-20)	Standardized shorter version of Lehman Quality of Life scale/Survey (Revised for COVID-19): Dimensions: living situation, everyday activities, family, social relationships, finances, safety, and satisfaction with life in general.
Food security	Food security Index	Standardized US Adult Food Security Survey Module (US AFSM) (Revised for COVID-19)/Survey
Community integration	Community integration Index	Standardized Community Integration Scale Instrument (CIS) (Revised for COVID-19)/Survey (see questionnaire)
Program engagement	Self-reported participation, frequent of participation, and personal willingness to participate in HFG program.	Module CD activities record/Mainstay TMIS/ Administrative data linkage

		Personal willingness to participate) /Survey
Corrections and court	Self-reported corrections and court data will collected to establish arrest, court appearance, incarceration previous they enrollment in HFG and 6 months prior data collections	Mainstay Social Impact Measurement (applied every 6 months)/ Administrative data linkage Survey (see questionnaire)
Healthcare Utilization	Service use events will be tracked using self-reported data. Regarding self-reported data, we will establish the number of hospitalizations, days in hospital, and emergency department (ED) visits over the six months previous the data collection.	Module on chronic disease/Survey Additional questionnaire with COVID-19 questions Mainstay Social impact measurement (applied every 6 months)/ Administrative data linkage
Substance use	Instrument: *GAIN-SS*	Standardized 5-question GAIN-SS questionnaire: Severity of substance use problems (such as getting into fights, problems at work, dealing with withdrawal symptoms) in the 'past month', '2–12 Months' or '1 or more years.' (Revised for COVID-19)/Survey
Mental Health	*Colorado Symptom Index (CSI)*	Standardized Questionnaire with 14 questions: presence and frequency of symptoms of mental illness experienced within the past month. (Revised for COVID-19)/Survey