Recent Academic Literature on the At Home / Chez Soi Study

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“Effect of Scattered-Site Housing Using Rent Supplements and Intensive Case Management on Housing Stability Among Homeless Adults With Mental Illness”
Vicky Stergiopoulos, MD*, Stephen Hwang, MD* et al.
JAMA March 3, 2015, Vol 313, No. 9

Introduction
- At Home/Chez Soi study was an un-blinded, randomized trial in Vancouver, Winnipeg, Toronto, Montreal, and Moncton that examined the effects of scattered-site supportive housing (SH) provided with Assertive Community Treatment (ACT) for high-need and Intensive Case Management (ICM) for moderate-need homeless people with mental illness.
- This article looks only at the results for the low-/moderate-need group provided with supportive housing plus ICM and includes only 4 cities because one city only provided ACT.¹

Design
- Homeless people with mental illness and moderate need were randomized to receive scattered-site SH with offsite ICM services versus usual care (housing and other services ordinarily available in the community).²
  - Case managers (caseloads 16-18:1) connected clients to available services and required weekly contact but did not mandate psychiatric treatment or sobriety.
- Outcomes were based on client self-report at regular interviews from baseline to 24 months.

Outcomes
- Primary: percentage of days stably housed higher in intervention group than control: 62.7% vs. 29.7% in city A (mean difference: 33%, 95% CI, 26.2% to 39.8%); 73.2% vs. 23.6% in city B (mean difference: 49.5%, 95% CI, 41.1% to 58.0%); 74.4% vs. 38.8% in city C (mean difference: 35.6%, 95% CI, 29.4% to 41.8%); 77.2% vs. 31.8% in city D (mean difference: 45.3%, 95% CI, 38.2% to 52.5%). Overall, by the 2nd year of the study 78% of the intervention group vs. 39.3% of the usual care group was stably housed half or more of the time (mean difference: 38.7%, 95% CI, 33.1% to 44.3%).³
- Secondary: overall quality of life change from baseline not statistically different for intervention vs. control group as measured by EQ-5D.

¹ For more on ACT branch of study, see Aubry et al. “One-Year Outcomes of a Randomized Controlled Trial of Housing First with ACT in Five Canadian Cities” in Pysh Services 2015. For full study, see National At Home/Chez Soi Final Report: http://www.mentalhealthcommission.ca/English/document/24376/national-homechez-soi-final-report.
² Participants were considered “high need” if they met the following criteria: “a current psychotic disorder or bipolar disorder based on the MINI, an MCAS score of 62 or lower, indicating at least moderate disability, and at least 1 of the following: 2 or more hospitalizations for mental illness in any 1 of the last 5 years, recent arrest or incarceration, or comorbid substance use based on the MINI. All other participants were classified as having moderate needs.”
³ Housing stability: “living in one’s own room, apartment, or house, or with family, with an expected duration of residence of 6 mo. or more or tenancy rights.”
* Centre for Research on Inner City Health, St Michael’s Hospital & University of Toronto
• **Exploratory:** no statistically significant differences in severity of mental health symptoms, psychological community integration, physical community integration, severity of substance use problems, number of arrests, emergency department visits, community functioning, risk of hospitalization.

• **Exploratory:** small but statistically significant improvements in quality of life scores for leisure, living situation, and safety in the intervention group vs. the control group.

**Limitations**

- *Secondary and exploratory outcomes* not adjusted for multiple comparisons, which makes it more likely that one or two significant effects might be found just by chance.
- *24-mo. study period* may be too short for full intervention effects to be clear. Observed benefits could also be short-lived. Future research should examine areas most likely to show “meaningful change” for longer periods.
- Overall *fidelity* to the Housing First model was good, though there was some heterogeneity among study cities.
- They used *self-reported data*, which may have limitations around accuracy. Privacy concerns prevented collection of administrative data for individual-level usage across provinces.
- This study *did not include* clients identified as having *high levels of mental health need*, for whom it might be easier to show benefits of an intervention.
“One-Year Outcomes of a Randomized Controlled Trial of Housing First With ACT in Five Canadian Cities”
Tim Aubry, MD* et al.
Psychiatric Services February 2015

Introduction

- At Home/Chez Soi study was an un-blinded, randomized trial in Vancouver, Winnipeg, Toronto, Montreal, and Moncton that examined the effects of scattered-site supportive housing (SH) provided with Assertive Community Treatment (ACT) for high-need and Intensive Case Management (ICM) for moderate-need homeless people with mental illness.
- This article looks only at the interim (12-month) results for the high-need group provided with SH plus ACT.4

Design

- Homeless people with mental illness and high-need were randomized to receive SH with ACT services versus usual care (housing and other services ordinarily available in the community).
  - Case managers (caseload 10:1) visited participants weekly
- Total sample size of 469 in intervention group and 481 in usual care group.

Results

- Housing: Percentage of days stably housed higher in intervention group than control: 77% vs. 31% at 12 months.5 Treatment effects did not vary significantly by site.
- Quality of Life: Both intervention and usual care groups reported improvements in overall quality of life, however absolute differences were much greater for intervention group as measured by QOLI-20 scores. Living situation, personal safety, and leisure also showed substantial absolute differences for intervention group. Treatment effects did not vary significantly by site except for the safety submeasure.
- Community Functioning: Both intervention and control groups had improvements in community functioning; however absolute differences were much greater for intervention group as measured by MCAS scores. Treatment effects did not vary significantly by site.

Limitations

- Authors used self-reported data, which may have limitations around accuracy.
- Authors do not report on health services use (e.g., emergency department visits).
- 12-month study period may be too short for full intervention effects to be clear.

4 Participants were considered “high need” if the met the following criteria: “a score of less than 62 on the Multnomah Community Ability Scale (MCAS) assessment of bipolar disorder or psychotic disorder on the Mini International Neuropsychiatric Interview 6.0 (MINI 6.0), at least two hospitalizations in one year of the past five years, a comorbid substance use disorder, or arrest or incarceration in the past six months.”
5 Stable housing: “living in one’s own room, apartment, or house or with family for an expected duration of at least six months or having tenancy rights (holding a lease to the housing).”
* Centre for Research on Educational and Community Services, University of Ottawa
“Housing as a Remedy for Chronic Homelessness”
Mitchell H. Katz, MD
JAMA March 3, 2015, Vol 313, No. 9

- This is an editorial accompanying the research article by Stergiopoulos, et al.

- Katz outlines the change in paradigm for supportive housing (SH) from a “Continuum of Care” approach to the currently accepted “Housing First” approach.

- Katz identifies an important aspect of the Stergiopoulos study: that it showed that a scattered-site model was effective at stably housing people.
  - He agrees that scattered-site housing may be easier to implement than congregate models, though also warns that it can be harder to provide as much support (e.g., case management) in scattered-site housing as in congregate housing.
  - He notes that the Stergiopoulos, et al. study excluded clients with the highest mental health needs (these were reported in a separate study by Aubry, et al.).

- Katz explains: “An important step toward substantially reducing chronic homelessness would be reimbursement for housing as medical service for persons who are chronically ill and covered by Medicaid, Medicare, and private insurance. One concern with this approach is a risk of undermining support for public insurance by placing too many societal burdens on these programs.”

- Katz notes that the US Department of Housing and Urban Development and local housing agencies could also expand housing, though reports that one barrier is that the savings due to housing provision accrue to different agencies (i.e., health care, though it should be noted that the Stergiopoulos, et al. article did not actually show any reductions compared to the control group in ED or hospital use for those placed in SH in Canada).

- Katz argues: “Clinicians who provide care for homeless persons are aware that they can order a variety of reimbursable tests and treatments for them, except the one intervention that most likely would make all the difference—supportive housing. There are many conditions medicine cannot cure; chronic homelessness does not need to be one of them.”

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6 County of Los Angeles, Department of Health Services, Los Angeles, CA
Supplemental Chart from full At Home / Chez Soi Study
Includes both moderate- and high-need clients who received Housing First plus Intensive Case Management or Assertive Community Treatment, respectively.

Emergency Department Use for Housing First and Treatment as Usual Group

ER visits decreased over time in both Housing First and Treatment as Usual groups.

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