

LITERATURE REVIEW AND BEST PRACTICES
FOR THE
HOUSING AND SUPPORTS FRAMEWORK;
HOUSING AND SUPPORTS INITIATIVE; and
CREATING CONNECTIONS: ALBERTA'S ADDICTION AND
MENTAL HEALTH STRATEGY

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EXECUTIVE SUMMARY

This review will highlight some key findings in the literature in the areas of community residential housing and relevant supports. The review will identify and describe practices that have been shown to be effective at providing stability and lasting community tenure for those persons who require assistance to remain housed. There is an overwhelming amount of good work and “best practices” reported and it is well known that information about many other excellent innovations is not available in the public domain.

It would be helpful if a consensus could be reached on one measure of housing stability that could facilitate a meta-analysis based on future studies. In addition to “housing stability” a core set of related outcomes should be developed.

Over the last fifteen to twenty years, research has demonstrated that the provision of housing along with tailored supports:

- Reduces hospital visits, admissions and the duration of hospital stays among homeless individuals and overall public system spending is reduced by nearly as much as is spent on housing.
- Results in greater reductions in the use of institutional services (hospitalization and jails/prisons) than participants in comparison groups.
- Was associated with substantial increases in outpatient services and days spent in housing. Reductions in costs of inpatient/emergency and justice system services generally offset the additional costs.

The cost savings are shared by governments at all levels that fund the emergency shelter system, prisons, police services, emergency rooms and mental health facilities. However, the upfront investment for housing subsidies and supportive services are usually not made by the same parties that will save money from its implementation.

Risk Factors of Homelessness

There are numerous personal risk factors that have been shown to contribute to an individual becoming homeless. The most common of these is severe addiction and mental illness. The cyclical and long-term nature of this illness affects gainful or sustainable employment. The precarious economic circumstances further contribute to unstable housing, potentially beginning one’s pathway to homelessness.

There are additional risk factors that add to the complexity of this social issue. Looking into the past of homeless individuals, many are found to have experienced institutional risk factors that include: arrest history, out-of-home placement as a child and mental health hospitalization. Individuals entering the pathway to homelessness soon discover that they may also experience further social-level risk factors as they attempt to acquire benefits from social programs, but find that they have difficulty accessing same as a result of eligibility criteria, especially income support.

Importance must also be placed on the assets and strengths that are shown to contribute to individual resiliency and to mitigate the potential of homelessness and include: positive relationships with family members and friends, positive coping skills and self-esteem, acceptance of personal responsibility, with an ability to set goals towards education and/or employment enhancements.

Prevention

One of the ways of reducing homelessness is by preventing it from ever happening. This requires stopping individuals and families who have never been homeless from losing their homes and for those who have left homelessness from re-entering it.

Research suggests a wide range of activities that assist many in preventing homelessness. Many of these activities have been implemented to varying degrees in Alberta. These include averting housing loss for households facing eviction through emergency financial supports, income support benefits, addiction and mental health services, education and advocacy to name a few.

Prevention activities that appropriately divert and/or relocate individuals and families and include the provision of on-going sources of community service support and basic safety net assistance have been shown to be successful. Further the identification and tracking of these individuals and families in mainstream systems; with the administration of housing stabilization services and inclusion of harm-reduction strategies have been shown to prevent and minimize repeated homelessness.

Housing and Support Models

There are significant barriers to establishing conclusive recommendations about the most effective housing models, primarily because of the nature of housing interventions and meta-analysis. Housing interventions are “socially complex services” that are difficult to operationally define and categorize. It would be ideal if housing initiatives could be developed with a specific evidence-based approach clearly outlined and the components of that model described prospectively, with a fidelity measure to accompany implementation.

Greater clarity, distinction and uniformity of definitions and terms should be applied to the descriptors of support in relation to housing and these descriptions should be based on adherence to specific, agreed-upon criteria for an identified supported housing model. There should also be some consensus on the elements of the supported housing model, and more precise operationalization of individual elements. This would not only guide the development and dissemination of programs, but would also facilitate evaluation research by standardizing evaluation criteria. In the early stages of a housing strategy, refinement of the model might initially proceed based on which elements are deemed “most important” given the spirit and core principles of the supported housing paradigm.

Housing First

This approach is now well known and has challenged traditional thinking about housing, especially for those with addiction and/or mental illness. While Housing First programs varied in areas such as congregate or dispersed housing, on-site or remote staff, abstinence requirements, the following were essential features:

- Access to a substantial supply of permanent housing
- Providing housing that clients like
- Wide array of services to meet the multidimensional needs of clients
- Service delivery approach that emphasizes community-based, client-driven services
- Staffing structure that ensures responsive service delivery, including access to multidisciplinary staff, regardless of case management model
- Diverse funding streams for housing and services

Transitional Housing

While transitional housing has drawbacks for many homeless persons, there are people who are most likely to benefit from transitional housing, including those who are recovering from traumas; lack social networks; have a background of multi-generational poverty; are exiting institutions without independent living skills; need skill training in order to obtain a living wage; have mental health problems; are attending addiction treatment; are physically or mentally disabled; or are recent immigrants.

Homelessness

People who are homeless generally share a number of experiences and characteristics that make their needs for housing with supports different from those of the general population. Service providers and formerly homeless research participants speak of the critical need for supports and services provided in conjunction with housing to be sensitive and responsive to the residual effects of the traumatic events experienced while homeless.

Homelessness disrupts important social bonds and impairs personal networking that could be instrumental in getting off the street. The street culture becomes a “way of life” that may keep individuals entrenched in homelessness. Interactions with a public that “expects” certain behaviour from homeless people based on stereotypes further solidify role identification as a homeless person. Their long-term sense of impermanence often continues even though they are housed, especially if they have experienced numerous failed attempts at attaining and retaining housing in the past. Being sensitive to the enormous disruption experienced by people when they move into housing after being homeless is critical to the individual making a successful adjustment to being a new tenant. It is important for the staff to understand the reasons why people acquire certain behaviours when they are homeless.

Preliminary findings of the Canada-wide At Home/Chez Soi initiative (MHCC, 2012) have confirmed that there are identifiable key elements to a housing and support approach and that these can be linked to specific positive outcomes.

Health and Accessibility Barriers

People in supported housing who are aging do not have access to health services and housing designs that accommodate aging in place. At a vulnerable time in their lives, they can find themselves unable to live in the housing that has been so helpful to them and the support services are inadequate to meet their changing needs.

While substance use and mental health remain major medical issues for the homeless, the aging trends that have been observed suggest that chronic health conditions will take on increasing prominence for homeless health services as the population ages.

A proactive approach to the design of housing and communities that accounts for changing abilities in persons as they transition through their lives is Universal Design. Some proponents suggest that if funding agencies begin to provide incentives to developers to use Universal Design principles, it could become more commonplace, in a similar way that ‘green building’ has evolved.

Universal Design is a framework for the design of places, things, information, communication and policy to be usable by the widest range of people operating in the widest range of situations without special or separate design. Most simply, Universal Design is human-centered design of everything with everyone in mind.

Snapshots of Homeless Sub-populations

Youth: The general assumption is that homeless youth are runaways who left because they didn't like the rules of regular family life. The idea of street life as a choice is a fallacy – "homeless youth are running away from something, not towards street life." For those who leave their family homes, they lose not only shelter, but also their supports and all that is familiar and become exposed to all the dangers from which the family is supposed to protect them.

In order to meet the complex needs of young people leaving care, such a model should involve inter-institutional collaboration between the provincial government, child protection services, the transitional housing provider, mental health services and corrections.

Over the last 20 years, as housing and integrated support services developed across the world, the arbitrary stratification of these services by age evolved from historical precedent. Youth transitioning to adult services often encounter barriers and the services are very different, built on different assumptions. For example, services for youth are usually more comprehensive, such as "wrap-around" services, while adult services generally expect the clients to advocate for themselves. Many young adults are lost in the first stages of this transition.

LGBTQ Youth: Compared to the homeless youth population overall, LGBTQ youth are more susceptible to developing mental health issues on the streets due to the stigmatization and unfair treatment associated with being a sexual and gender minority. Alarming high rates of depression, suicide, and suicidal thoughts have been reported by LGBTQ homeless youth.

Women: Compared to men, homeless women use many informal strategies that render them less visible in order to avoid the increased physical and sexual danger associated with living either on the streets or in co-ed emergency shelters. Women who are homeless are often accompanied by children, and the housing and supports they require differ as a result. Homeless women and other survivors of abuse and trauma need privacy, control, and safety if they are to succeed in residential placements.

Incarcerated persons and Not Criminally Responsible persons at risk of homelessness: Exiting prisoners face important challenges to successfully reestablishing community life, including difficulties with securing housing and employment. They also have difficulty obtaining medical, mental health, and substance abuse treatment after their release. Lengthy periods of incarceration in remote locations often attenuate the social and family ties that are crucial for successful reentry into the community. Former prisoners are among the heaviest users of shelter services and are generally in the shelter system for more than six months. They have a 30 percent chance of spending more than one year in a shelter. Homeless and prison populations have high rates of communicable diseases because of poor health, unsafe sexual practices, illicit drug use, and close living quarters. Most housing initiatives have not been established specifically to consider the needs of those who have been diverted from imprisonment because of their mental illness. The Calgary Community Rehabilitation Program will be the first appropriately structured, supervised and supported residential living program in Calgary for individuals deemed either Not Criminally Responsible (NCR) or Unfit to stand trial due to a mental disorder.

Aboriginal persons: An environment that supports Aboriginal culture and spiritual practice and teachings is central to success: gathering areas for ceremony and community; acceptance of smudging; acknowledgement of the importance of supporting family members; the creation of sacred spaces.

Spiritual practices were key, not only in Housing First, but also in healing the Aboriginal community. Culturally sensitive treatment for addictions, rooted in Aboriginal spiritual practices and immediate access to housing and recovery programs are also essential.

Immigrants, refugees and refugee claimants: Housing with supports for homeless immigrants/refugees/refugee claimants would need to offer units large enough to accommodate larger newcomer families. A promising practice that would meet this need is inclusion of flexible housing units that can individually house separate smaller households when needed and also have the capacity to open (via common doors or moveable walls) to connect multiple spaces. Long-term affordable transitional housing with optional supports provided on-site (up to three years) has proven to work well with newcomers.

Homeless people with pets: An overlooked issue is the value of pets to homeless persons. They offer companionship, comfort, a sense of responsibility and safety and the pet owners will usually prefer to remain homeless than accept housing that requires them to give up their pets. Studies have shown the extreme attachment that homeless people have with their pets, as these companions are viewed as their only source of love and companionship. Based on the findings of the numerous benefits associated with owning a pet, homeless-serving agencies should explore ways in which pets may be incorporated into their programming.

Housing Policy

A comprehensive affordable housing policy for Canada is a responsibility shared between all levels of government and local communities. Policies and legislation should build and expand on the existing federal housing and homelessness initiatives, ensure housing system components such as home ownership, rental housing, social housing and emergency shelter are functioning to provide all citizens with a decent and secure place to live. They should also invest in the housing system to provide a range of appropriate housing solutions for diverse populations, including low income Canadians and people with special needs.

In 2008, the Alberta Secretariat for Action on Homelessness was appointed with a mandate to develop and implement a provincial plan, which included rapid re-housing of homeless Albertans, moving them from streets and shelters into permanent housing; providing client-centered supports to re-housed clients, helping them obtain the assistance they need to restore their stability and maintain their housing; and preventing homelessness through emergency assistance and by providing adequate and accessible government programs and services to Albertans. Many provincial and municipal jurisdictions in Canada have implemented plans to end homelessness.

International Efforts in Housing and Supports

The U.S. has been the primary innovator in housing solutions in the last decade, with successful experiments such as the Clubhouse model and Housing First. In Washington State, system redesign has focused on keeping at-risk families linked to services; establishing a common way to access homeless services, rapid re-housing, tailored programs and economic opportunities. Germany has been able to establish, through its subsidy and incentive policies, a strong inventory of affordable housing and housing cooperatives have been a priority, resulting in high quality and reasonable options.

In Australia and Europe, there have been questions about the transferability of Housing First programs to different contexts. Finland has established an ambitious national strategy, with aggressive timelines for reducing homelessness and converting homeless shelters into supported housing units. Emphasis has been placed on the prevention and homelessness. The UK has lost momentum on homelessness with

government constraint. Some NGOs, such as the non-profit organization Shelter, continue to seek innovation and have modified concepts such as harm reduction [“wet housing”] and therapeutic communities.

Some jurisdictions have experienced reluctance on the part of NGOs to move to new models after years of established practices. They will need some additional support and resources in the transition, especially with the requirements for outcome measurement.

The Alberta context

Under Alberta’s 10-year plan to end homelessness by 2019, funding is being provided to community-based organizations in the seven major cities, which work with community partners to deliver services necessary to meet the unique needs of the homeless. Funding is allocated based on factors such as population and shelter space usage in the community. Housing First is a key approach in this plan.

Funding is used for supports such as intensive medical, psychiatric and case management services to help people resolve the underlying causes of their homelessness. These services are key to ending homelessness, because they help those who are now housed to stay housed and keep on track to independence.

The plan has five priority areas for action: robust information on outcomes, aggressive assistance, coordinated systems, increased housing options and effective policies.

NIMBY

The literature is unequivocal in concluding that residential programs are most likely to be successful when they are located within natural communities, and when they provide opportunities for community reintegration. The most significant barrier, besides an adequate inventory of community supported housing, is the anxiety-based forecasting of economic devaluation, increases in crime and other concerns that are part of NIMBY [Not In My Back Yard].

The research on the impact of locating supported housing, transitional housing and affordable housing in established neighbourhoods is very uniform in reporting that these units do not negatively impact surrounding homes.

Solutions to NIMBY have been effective when they are implemented throughout the development process. Design teams that seek to address neighborhood concerns from the beginning of this process can be rewarded with strong support for the project. It is important to approach the community from a positive stance of contribution to the community, rather than trying to mitigate a so-called “liability” for the community. Instead of asking how the impact of the supported housing project on the community can be minimized, developers should ask how this opportunity could be used to address neighbors’ concerns regarding their neighborhood.

Housing strategies, if they are to be successful, will seek to integrate the interests of multiple government sectors, NGOs, private sectors and clients and their support systems. This is an ambitious task. “Designing affordable housing requires imagining clear solutions to often conflicting ideas and input; it is the artful resolution of the multiple goals, aspirations, and expectations of many people” (Davis, 1995).

INTRODUCTION

The main purpose of this literature review is to profile promising and best practices in any jurisdiction in the world [with an emphasis on the Canadian context]. These innovative or sustaining practices will align with the research outcomes and experiences of clients and their families and will offer opportunities for Alberta to learn from the exceptional efforts to prevent and reduce homelessness.

Over the last fifteen to twenty years, research on supported and affordable housing has very clearly demonstrated that the provision of housing and related supports:

- Reduces hospital visits, admissions and the duration of hospital stays among homeless individuals and overall public system spending is reduced by nearly as much as is spent on housing (Larimer, 2009).
- Results in greater reductions in the use of institutional services (hospitalization and jails/prisons) than participants in comparison groups (Nelson et al., 2007).
- Was associated with substantial increases in outpatient services and days spent in housing. Reductions in costs of inpatient/emergency and justice system services generally offset the additional costs (Gilmer et al., 2010).

The cost savings are shared by governments at all levels that fund the emergency shelter system, prisons, police services, emergency rooms and mental health facilities. However, the upfront investment for housing subsidies and supportive services are usually not made by the same parties that will save money from its implementation (Cohen, 2008).

In B.C. the Centre for Research in Mental Health and Addiction at Simon Fraser University, looked at the costs and savings associated with providing adequate housing. Regarding the absolutely homeless, non-housing service costs amount to about \$644.3 million per year across the province. In other words, the average homeless adult with substance abuse and mental illness in BC costs the public system in excess of \$55,000 per year. Provision of adequate housing and supports is estimated to reduce this cost to \$37,000 per year. This results in an overall 'cost avoidance' of about \$211 million per year. The 'cost avoidance' in health care and provincial corrections institution costs are more than sufficient to offset the capital costs and the costs of providing housing supports to those who are absolutely homeless (Patterson et al., 2008).

A 2011 study of the homeless in Edmonton, Alberta, reported that the ten highest system users among the homeless cost the health system \$3,578,715 in a single year (2007/08 data), representing 8% of the cost of serving the homeless that year. These ten users represented only 0.3% of the 3,079 homeless individuals identified in Edmonton by the 2008 homeless count (KPMG and OrgCode Consulting, 2011).

With this cost-benefit case for providing housing with supports as the foundation, this review will look beyond to gather and analyze research findings that describe and analyze models of housing with supports, in order to learn from other jurisdictions what has proven to work well and not work well for those populations that can benefit from integrated provision of housing and supports.

The purpose of this review of academic and grey literature and best practices is to inform the development team of the Housing and Supports Framework about published successes throughout the world as well as learning from initiatives that did not achieve objectives. The scope was not limited to the topic of housing with supports for homeless people and those with addictions and mental health issues, but also covered issues related to housing and supports for a diversity of populations through the

lifespan and across many jurisdictions. This review could be used as a resource for internal policy and service development within Government of Alberta and Alberta Health Services. It is designed to offer a high degree of confidence that any policies or services can be aligned with, or informed by, the available evidence in housing and supports and/or interventions with homelessness.

This is an overview of a vast expanse of literature reviews, jurisdictional reports, knowledge exchanges and other sources of data and analysis on housing with supports for a diversity of populations throughout Canada and other nations. There is a great deal of work that has been done to evaluate particular housing practices, and there has been exceptional work done to survey the current state of knowledge. The approach taken here has been to make every effort to concisely report on consistent findings in this literature and to pay close attention to any published data on the challenges and solutions to issues connected to housing with supports as well as to the unintended and/or unanticipated consequences of these solutions.

The literature is variable in dimensions of rigour, focus and type of analysis. This review focused on findings about specific housing with supports programs or approaches from research that met as many of the following criteria as possible:

1. Undertaken by an independent researcher (i.e., not the program proponent);
2. Includes a control group or a baseline measure as comparison;
3. Takes into consideration other factors that may have influenced outcomes, such as changes in the economy, vacancy rates, public support or resistance, funding changes, socio-demographic characteristics of clients that may affect program outcomes, etc. (i.e. those that did a thorough causal analysis);
4. Includes input from clients/users receiving supports;
5. Clearly explains the program and notes any deviation/variation from the standard approach and/or other programs to which it is being compared;
6. Uses some form of indicator of success in addition to the standard outcome of housing stability, usually defined by “% of clients who have remained housed for (whatever time frame identified).” This recognizes that housing stability is not the “be-all-end-all”, but that it also provides the context for a wider range of positive outcomes to occur;
7. Employs rigorous methodology, using solid research tools, explanation of limitations of the study, and consideration of the generalizability of the findings.

One systematic and comprehensive review of the housing with supports literature stated that it would be helpful if a consensus could be reached on one measure of housing stability that could be used across studies, which could facilitate a meta-analysis based on future studies. In addition to “housing stability” a core set of related outcomes should be developed including the number of days homeless in a follow-up period, days or times hospitalized, time to first housing placement, number of residences occupied in a given period of time (i.e., number of residential moves), time to first failure (leaving a residence). All of these indicators of secondary outcomes, and more, appear in the literature. It would be useful if there was consensus for a core set of these secondary measures as well as the primary measure of housing stability (Center for Psychiatric Rehabilitation, 2008).

It is difficult to establish rigour in examining housing with supports and homelessness due to the complexity of these issues. A recent review of new research that examined interventions to increase access to health and healthcare for people who were homeless or at risk of homelessness looked at 1546 articles. Less than 1 per cent of those articles met the authors’ inclusion criteria that established

sufficient scientific validity. However, despite this, the author contended that there was sufficient evidence in those articles that were included to support the efficacy of housing interventions for people with mental illness, substance abuse, HIV, with homeless youth, homeless women, and homeless families and children (Fitzpatrick-Lewis et al., 2011).

There is an overwhelming amount of good work and “best practices” reported and it is well known that many other excellent innovations have not been well-researched or published and therefore descriptions of them are not available in the public domain. This review will highlight some key findings in the literature regarding practices that have been shown to be effective or are promising. It will be up to other experts within the Housing and Support Initiative to determine which of the practices, or key elements of models, are most relevant and which can be implemented in the Alberta context.

Prevention strategies are increasingly identified as a key part of any comprehensive plan to address and end homelessness. Research demonstrates there are a number of key initiatives that contribute to homelessness prevention (Hughes, 2011). Key factors in providing help to at-risk populations will be summarized as well.

There will be a report on key statistics regarding the prevalence of homelessness and its costs through ongoing utilization of health and emergency services, involvement in the justice system and other government sectors. Homelessness is a complex issue and distilling this into a brief report is challenging. While recognizing these limitations, it is vital that the challenges and successes involved in ending homelessness, as presented in the literature, are described as part of a comprehensive overview of housing strategies.

The literature review will present examples of national, provincial and municipal policies and/or legislation that have documented evidence of improved outcomes in any of the areas of reduced homelessness, community acceptance, shifts in public perception, effective supports to housing initiatives and housing stability.

Key Assumptions of the Literature Review:

- Best practices are included when they have significant positive and lasting outcomes and/or are cited in two or more sources; this will skew the best practice section towards initiatives that have had sustained support and scrutiny and have managed to connect with resources that were able to publish results.
- The published literature may not include solutions and ideas generated within smaller constituencies that could easily be generalized to larger-scale approaches and initiatives.
- Definitions: the literature uses several terms interchangeably. In order to avoid confusion, these terms will use the following meanings throughout this review:

Disability: Since disability in some form is frequently a core cause of homelessness or a key barrier to a sustained solution, it is important to consider that the way disability is defined and understood has changed in the last decade. The World Health Organization (WHO) has moved toward a new international classification system, the International Classification of Functioning (ICF), Disability and Health (ICF 2001). It emphasizes functional status over diagnoses. The new system is not just about people with traditionally acknowledged disabilities diagnostically categorized but about all people. For the first time, the ICF also calls for the elimination of distinctions, explicitly or implicitly, between health

conditions that are 'mental' or 'physical'. The new ICF focuses on analyzing the relationship between capacity and performance. If capacity is greater than performance then that gap should be addressed. The new WHO ICF specifically references Universal Design as a central concept that can serve to remove barriers and identify facilitators that can benefit all people (Institute for Human Centered Design, 2011).

The terms “supported” and “supportive” housing are often used interchangeably in the literature to mean the same thing, at times, and at other times to represent distinct types of housing with supports. This review aims to keep the two terms as representing two distinct configurations of housing with supports.

Supported housing

- There are no staff members on-site. If a resident needs further assistance to live independently, case management is often used to provide this support. Supported housing features independent apartments, housing co-operatives or other government funded social housing for people with low incomes. Residents often have some choice over their housing and also are often in control of the amount of support provided. (the Centre for Addiction and Mental Health [CAMH])

Supportive housing

- Housing and support are linked. This means that staff members usually work in the residences to provide support. The amount of hours that staff spends on-site depends on the level of assistance needed by the residents. Supportive housing can be group home settings, low-support self-contained apartments, or high-intensity congregate housing. Residents in supportive housing have limited choices in their housing setting and do not usually have a choice over who lives in the house with them or their neighbours. (CAMH)

Housing with supports

- This term will be used in this review when referring to all types of housing that has some form of support linked to it, including both supported and supportive housing.

Dual Diagnosis

In the United States, dual diagnosis is used to denote persons with a mental illness and substance use disorder, also referred to as Concurrent Disorders. In order to maintain some distinction, this review will try to confine its use of the term “dual diagnosis” to the following definition, from the Canadian Mental Health Association:

- In Canada, dual diagnosis usually refers to an individual with a mental illness and a co-occurring developmental disability. An individual with a developmental disability has significantly below average intellectual functioning, which is also accompanied by considerable limitations in their adaptive functioning or life skills.

In this review, every attempt has been made to replace “dual diagnosis” with concurrent disorder when it does not denote the above but instead is referring to concurrent disorders, as below.

Concurrent Disorders

“Concurrent disorders”, “co-occurring disorders” and “dual diagnosis” are often used interchangeably in the literature. There are also Canadian references to Substance Abuse and Mental Illness [SAMI]. The acronym SAMI is used in this review with certain references in which SAMI is frequently embedded in the publication. Otherwise, the term Concurrent Disorders will be used to denote the following:

- When a person is experiencing one or more active substance use issues (abuse or dependence) and one or more mental disorders at the same time.
- A diagnosis of concurrent disorders occurs when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from the one disorder. (adapted from: U.S. Substance Abuse and Mental Health Services Administration’s Co-Occurring Center for Excellence)¹

While the literature is universal in agreement that any interventions or treatment of any person with a health or an addiction problem should take place with housing as one of the main pillars of recovery, there are many housing with supports models and variations of models in use. These will be defined and described briefly and this review will also highlight prevailing needs for housing to be coupled with supports but will also identify and describe a range of sub-populations that require specific supports and strategies.

The review will provide recommendations that follow naturally from the available evidence. These recommendations will not be exhaustive but hopefully will be a good starting point and guideline for future planning and programming that will be examining this issue and potential solutions in far more depth.

Two appendices are included; one provides a more detailed description of the examples of best and promising practices, the other is a complete list of recommendations from a group of clients who were carefully interviewed regarding their experiences with housing and with being at risk of homelessness due to their disabilities and, more so, to the stigma associated with their disabilities.

Finally there is a bibliography, which contains the citations for any article that was utilized in some way in compiling this review. These articles were found through internet searches of PubMed and other databases using key search terms such as homelessness, mental illness, addiction, housing, supportive housing, supported housing, affordable housing. Articles were chosen for detailed review if they were meta-analyses, reviews of published data, cited in several other papers or if they were reviews of the literature. Most of the material reviewed dated from 2005 to present. There are a few exceptions, when some data or conclusions were presented in a particularly compelling manner. Some websites [e.g., Substance Abuse and Mental Health Services Administration (SAMHSA), Homeless Hub, Mental Health Commission of Canada (MHCC) Knowledge Exchange] were central repositories of published and reviewed material. Members of the literature review who have conducted similar reviews in the past provided other articles and reports. The combined expertise of the literature review team allowed access to well-researched material in a timely way.

¹ Concurrent Disorders specialists generally accept the above definition, including those in Canada. This is the definition followed in this review.

RISK FACTORS OF HOMELESSNESS

“The paths to homelessness are as complex and varied as the homeless population itself” (Echenberg & Jensen, 2009).

Homelessness has become a pressing social issue in Canada and other Western countries. To ensure that service delivery for homeless populations is effective and productive, it is essential to gain a better understanding of the biographical risk factors that lead individuals to the pathways of homelessness (Shelton et al., 2009).

There are a large number of risk factors that contribute to homelessness. In general, these may include: mental illness and substance abuse; marital breakdown and a history of abusive relationships; transitions out of institutionalized care; poverty and affordability issues; reduced availability of social assistance and social housing (Echenberg and Jensen, 2009; Shelton et al., 2009).

For populations challenged with severe addictions and mental health (SAMI), Patterson et al. (2008) suggest additional factors contributing to homelessness: deinstitutionalization, unstable housing, inadequate discharge planning and community follow-up, lack of affordable housing and changing economic factors.

The very nature of SAMI challenges may, in and of itself, contribute to homelessness as a result of the cyclical and long-term nature of the illness. Inability to gain or sustain employment results in limited incomes resulting in individuals with SAMI living in precarious economic circumstances (Canada Mortgage and Housing Corporation, May 2003; Canada Housing & Mortgage Corporation, 2006). To bridge this gap, and in an attempt to acquire benefits from provincial and/or federal programs for the disabled, many have difficulty accessing same as a result of eligibility criteria. When benefits are finally accessed any benefits lost or temporarily suspended may further contribute to homelessness (Patterson et al., 2008).

Apicello (2010) elaborated on these risk factors, categorizing them into three separate levels (Figure 1): (1) the individual level: single individuals or families who are currently homeless, formerly homeless or at-risk of homelessness; (2) the institutional level: community institutions or facilities that can be public or private and that provide either formal or informal services to people who are homeless or at-risk of homelessness; and (3) the social level: the characteristics of larger social systems, which include social, economic, political and cultural forces. This research further identified the following risk factors associated with each of these levels:

FIGURE 1 – RISK FACTORS LEADING TO HOMELESSNESS

Individual Level	Institutional Level	Social Level
<ul style="list-style-type: none"> • Education and work experience history • Lack of social support • Mental health • Minority status • Physical health, including HIV status • Recent eviction • Recently doubled-up with another household • Substance abuse • Trauma history or history of abuse • Veteran Status 	<ul style="list-style-type: none"> • Arrest history • Out of home placement as a child • Recent mental health hospitalization 	<ul style="list-style-type: none"> • Crowding • Decline in low-cost, subsidized, or affordable housing / high rent-to-income ratios • Decreasing living wages and changing labour market • Increasing income inequality • Local poverty rate • Public policy regulations • Rent stabilization regulations

Source: Apicello, 2010

Research suggests that the more risk factors which an individual may experience, the greater the likelihood that they may experience housing insecurity and, ultimately, homelessness. In contrast, Tutty et al. (2009) point out, that the assets which one may possess may contribute to their resiliency, thereby avoiding homelessness. These may include: positive relationships with family members and friends, positive coping skills and self esteem, acceptance of personal responsibility, with an ability to set goals towards education and/or employment enhancements.

HOMELESSNESS PREVENTION

Homelessness is indisputably an undesirable condition that negatively impacts not only people, but also society in general. The many negative effects caused by homelessness would be reason enough to consider why one would want to prevent it, for any strategies implemented to prevent it would also reduce the number of new cases, effectively ending homelessness (Burt et al., 2005; National Alliance to End Homelessness, 2000).

Effective strategies can only be developed with knowledge of the causes of homelessness, and with the understanding of what precipitates some individuals faced with these risk factors from experiencing housing insecurities and, ultimately, homelessness and others not. Netto et al. (2009) describes such effective strategies as enabling a household to remain in their current home, where appropriate, or supporting options for a planned and timely move or helping to sustain independent living.

Homelessness Prevention Frameworks

Research describes three frameworks that guided the development of prevention approaches and activities assisting the homeless population. These include:

- 1) The Public Health Framework
- 2) The Institute of Health (IOM) Framework, and
- 3) The Population Health High-Risk Framework

Public Health Framework

A traditional prevention framework used in public health, Apicello (2010) highlights its three levels of prevention: primary, secondary and tertiary as distinguished below.

- **Primary prevention** – Primary prevention activities seeks to reduce the risk of homelessness among the general population or large parts of the population, by targeting people who are housed (Apicello, 2010), in an effort to prevent new cases of homelessness (Culhane et al., 2011). This first level of prevention includes measures involving broad housing policies including supply, accessibility and affordability as well as services such as income benefits, housing benefits and job protection (Busch-Geertsema & Fitzpatrick, 2008).
- **Secondary prevention** – Secondary prevention activities would seek to identify and address conditions at its earliest stages, such as when they enter shelters (Apicello, 2010). This includes people who have been in institutional care or those in crisis situations such as eviction or relationship breakdown, which are likely to lead to future homelessness. Busch-Geertsema & Fitzpatrick (2008) maintain that most homelessness prevention interventions tend to focus on secondary prevention measures. While these programs may reduce the total number of people affected at any time, they do not reduce the number of new cases of homelessness (Shinn et al., 2001), but rather attempt to treat conditions close to their onset, at a time when they are easier to counteract (Culhane et al., 2011).
- **Tertiary prevention** – Activities developed for tertiary prevention attempts to slow the progression or mitigate the negative effects of homelessness once it has become established, by targeting people who have been homeless for some time. Prevention initiatives focus on harm reduction activities to minimize repeated homelessness (Apicello, 2010).

Culhane et al. (2011) further suggests that these prevention activities should be seen as a continuum of care as the boundaries between each are somewhat indeterminate.

The Institute of Medicine (IOM) Framework

The three prevention categories used within the IOM Framework include:

- **Universal Prevention** – “Universal prevention programs are intended for the entire population, although they are sometimes targeted at people at a particular stage of life.” These are strength-based programs used to reinforce individual assets, or change people’s structural environment (Shinn et al., 2001; Apicello, 2010). Universal prevention is intended to promote the health of the population or delay the onset of problems. In the case of homelessness, universal prevention strategies may include programs to combat poverty including initiatives to create employment training and job opportunities, as well as increase access to social services, better education and affordable housing as part of broader community planning and public policies (Shinn et al., 2001).
- **Selected or Targeted Prevention** – “Targeted prevention is directed towards people who have risk factors related to specific problems, but who are not currently experiencing these problems. The intent is to decrease potential problems, reduce the influence of risk factors and enhance protective factors (Alberta Alcohol and Drug Abuse Commission, 2002). In the context of homelessness, selected prevention programs may target people with low incomes who find it difficult to afford housing, or entire neighbourhoods where there are large concentrations of homeless people (Shinn et al., 2001).
- **Indicated Prevention** – “Indicated prevention programs are directed at people who are at-risk because of certain individual characteristics, determined by individual-level screening.” The focus is on individuals with less emphasis placed on environmental or structural factors (Shinn et al., 2001; Apicello, 2010). Indicated prevention targets people already experiencing problems who may or may not be ready or able to engage in a formal intervention. The intent is to reduce the harm (Alberta Alcohol and Drug Abuse Commission, 2002).

The Population and High-Risk Framework

The development of homelessness prevention programs is also influenced by the population and high-risk framework. Focusing on direct interventions targeted to those most at-risk of losing their homes while maintaining certain aspects of a population-based approach to homelessness prevention, it is argued that concentrating resources towards the most vulnerable individuals is more cost effective than thinly spreading finite resources across an entire population. High-risk prevention strategies identify appropriate target populations, based on unique risk factors known to impact the chance of homelessness, complemented with population-level strategies such as those addressing the supply of affordable housing and sufficient income (Apicello, 2010).

Table 1. Comparison of Prevention Frameworks

	Prevention Framework		
	Primary/Secondary/Tertiary Prevention	Universal/Selected/Indicated Prevention	Population/High-Risk Prevention
Goal	Prevent new individual cases and prevent worsening of condition among existing cases	Prevent cases among indicated individuals and in selected populations, and prevent incidence in the general population	Prevent cases among high-risk populations and prevent incidence in the general population
Temporality	Prevent new cases and mitigate the harm among current cases	Prevent new cases	Prevent new cases
Target Population	Individuals with risk factors for the condition and who currently suffer, or have suffered from the condition	Entire population; high-risk populations; high-risk individuals	Entire population; high-risk populations
Distinguishing Differences	Focus is on the timing of interventions	Focus is on the target population	Focus is on the context and causes of the preventable condition

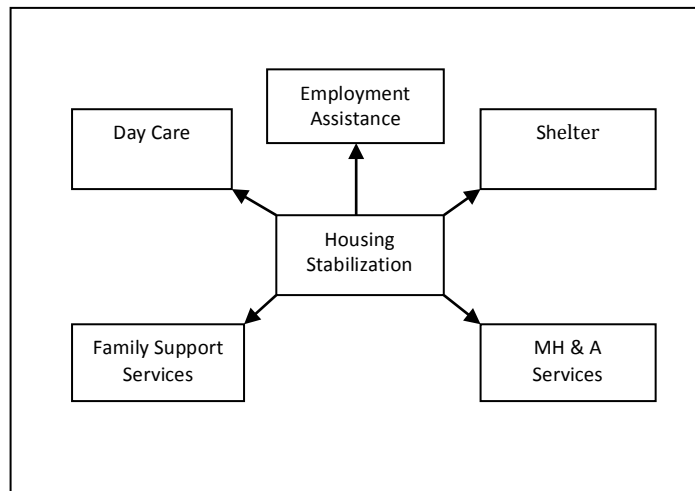
Source: Apicello (2010)

A number of approaches place shelters as the central focus, with housing as the end-goal. They focus on a model of continuum of care, primarily by providing emergency and transitional shelter facilities (Culhane & Metraux, 2008).

Housing Stabilization Model

Culhane et al. (2011) endorse a 'housing stabilization model', which is a modification to the present system, trading the continuum of care for a much broader connection to the very mainstream community-based systems known to support antipoverty assistance and social services. Figure 1 illustrates this approach with housing as its central theme, embedded in a larger, more pro-actively housing stabilization focused network.

Figure 1 – Emerging Housing Stabilization Model



Source: Culhane et al. (2011)

This system would focus more directly on helping people obtain and retain their own housing, with supports as required, than by the current system of shelters (Culhane & Metraux, 2008). It would be provided to all individuals, facing acute or imminent housing loss, with the basic idea that individuals and families would be appropriately diverted or relocated based on their circumstances and would be provided to all in need and not only to those who remain homeless, and would include the following characteristics (Culhane et al., 2011):

- Individuals would be assisted to resolve their crises by accessing on-going sources of community service support and provided with basic safety net assistance (i.e. emergency shelter, temporary rental assistance) as needed
- Multi-agency commitment would identify and track signs of homelessness in mainstream systems, and include their support and participation in the resolution of housing instability, and
- Each community would identify appropriate entities to administer the new set of housing stabilization services

Culhane & Metraux (2008) further recommend that the shelters or transitional residential programs remain for individuals requiring short-term shelter and services, designed for specific populations of single adults leaving institutions; greatly reducing need for congregate shelters and reducing individual exposure to victimization and dehumanization.

HOMELESSNESS PREVENTION ACTIVITIES

With these frameworks in mind and as part of their research developed for the U.S. Department of Housing and Urban Development, Burt et al. (2005) researched the various activities which were developed as a result of the frameworks and synthesized prevention activities being implemented in the United States, into the following three categories: I) Most Commonly Offered Activities; II) Less Commonly Offered Activities, and III) Sometimes Mentioned as Deep and Long-Term Prevention Strategies. Examples of implemented activities and strategies associated with each of these categories can be found in Appendix B: Best and Promising Practices.

Homelessness Prevention Activities in the Alberta Context

As a result of a provincial environmental scan completed in Alberta in 2011, the Addiction and Mental Health - Housing Supports Portfolio, Alberta Health Services, learned that many of the activities described above are currently being implemented in numerous communities throughout Alberta. Further research is required to determine extent of implementation and if the outcomes experienced are similar to those experienced in the United States.

Best and Promising Practices for Essential Service System Components in Canada

In support of the suggestion that the afore-mentioned activities support individuals at-risk of homelessness, Patterson et al. (2008) outlined a number of essential service system components, outlined below and described in Appendix B (Table 2), which evidence-based and promising practices have shown to benefit the SAMI population in British Columbia, who are at particular risk of homelessness. This research further suggests that this population can live successfully within a wide range of supported housing approaches when accompanied by the following components:

- Outreach and engagement
- Multi-disciplinary treatment teams/Intensive case management
- Integrated treatment for concurrent disorders
- Motivational Interventions
- Modified therapeutic communities
- Involvement of consumers and recovering persons; self-help programs
- Primary health care
- Mental health and substance abuse treatment
- Psychosocial rehabilitation
- Income support and entitlement assistance; employment, education and training
- Services for marginalized individuals within the SAMI population focused on the specific needs of women and Aboriginal people
- Low barrier service
- Crisis care
- Family self-help and advocacy
- Cultural competencies
- Criminal justice initiatives

MODELS OF HOUSING WITH SUPPORTS

There are significant barriers to establishing conclusive recommendations about the most effective housing models, primarily because of the nature of housing interventions and meta-analysis. Housing interventions are “socially complex services” that are difficult to operationally define and categorize (Leff SH, 2009). Most researchers in this area cannot be confident about what is being compared to what. Housing model terminology is frequently interchangeable, especially supported and supportive housing definitions. Not only is there a lack of clarity in categorization, the components of a specific model may vary from study to study.

One of the difficulties encountered in describing housing models that include support as a component of the housing model is that the individual components of support approaches are not often identified in the published literature. There are good reasons for this gap in the published literature. The individual components of supports vary from one context to another because the most effective of these approaches are client-centered and tailored to the individual. Unfortunately, this makes it difficult to compare approaches but more importantly can lead to general conclusions about the effectiveness of a type of support when, in reality, the difficulty lies in the operationalization of a single component of the support model.

In many studies, more consistency in the type of housing outcome measures would allow for meaningful comparisons. One article recommended that measures of the number of days housed over a specific period would provide a more precise estimate of housing stability (Nelson et al., 2007).

In reviewing the literature, it is not clear if the extent of these differences is model-driven (deliberately based on a meaningful theoretical framework) or whether they are at least partially driven by funding, availability of resources or other systemic constraints, or if they have been changed to adapt to local opportunities, conditions, and constraints. It would be ideal if housing initiatives could be developed with a specific evidence-based approach clearly outlined and the components of that model described prospectively, with a fidelity measure to accompany implementation.

A further complication in reviewing outcome measures is that when elements of a model of support are identified, the terms are subjective and unquantifiable. An example of this would be descriptions of decision-making and choice. Many studies do not specify the range of choice offered to a potential housing client and the extent of the locus of control regarding decisions about support and involvement of support workers.

Greater clarity, distinction and uniformity of definitions and terms should be applied to the descriptors of support in relation to housing and these descriptions should be based on adherence to specific, agreed-upon criteria for an identified housing with supports model. There should also be some consensus on the elements of the housing with supports model, and more precise operationalization of individual elements. This would not only guide the development and dissemination of programs, but would also facilitate evaluation research by standardizing evaluation criteria. In the early stages of a housing strategy, refinement of the model might initially proceed based on which elements are deemed “most important” given the spirit and core principles of the housing with supports paradigm.

One study's objective (Tabol et al., 2010) was to describe the extent to which the model of support and its individual elements were addressed and adhered to in existing studies of housing with supports (and housing programs sharing similar characteristics).

The question that the researchers wanted to address was what factors, including program elements, mediate the successful outcomes associated with housing with supports models. These elements cannot be identified without adequate specification of the programs being researched, without systematic procedures for program implementation, or without standardization of evaluation research methodology utilizing randomized designs. These evaluation tools are not usually reported in the housing with supports literature. This study did identify one fidelity measure: the Fidelity Assessment for the Center for Mental Health Service (CMHS) Housing Initiative, which appears to be the only fidelity instrument available for housing programs of this type. According to Tabol et al., the instrument has a number of strengths, including its attention to matters of housing choice and to safety and quality of housing, as measured by Housing Quality Standards of the U.S. Department of Housing and Urban Development [HUD]. Tabol et al. reported that the instrument uses well-operationalized, quantifiable criteria (such as percentage of income spent on rent) for deriving fidelity scores (Tabol et al., 2010).

General Positive Outcomes with Housing with Supports

Despite these drawbacks to the ongoing research into the effectiveness of housing with supports, there are consistent positive outcomes reported. Some examples of research in the last decade are summarized below.

A positive relationship has been reported between supported housing and various measures of social and occupational functioning for persons with substance use or mental disorders. Individuals who are randomly assigned to housing (versus usual community care) have significantly higher monthly income and lower incarceration rates two years later. As well, people with substance use or mental disorders tend to remain in supported housing once it has been provided (Jason et al., 2006).

Supported housing for homeless people with mental illness results in housing outcomes superior to those of intensive case management alone or standard care, while incurring modest increases in societal costs (Rosenheck et al., 2003).

Results suggest that housing and other supports beyond clinical/medical management, such as employment and education support, should be an important part of the treatment and support continuum available to people with severe mental illness and substance use disorders (Davis & O'Neill, 2005).

Providing permanent supported housing² to homeless people with psychiatric and substance use disorders reduced their use of costly hospital emergency department and inpatient services, which are publicly provided (Martinez & Burt, 2006).

² This is an example of the use of the more specific term "supported housing" when the referenced study clearly used housing and supports as specifically defined in the introduction to this review. When the model studied is not known, the more general term "housing with supports" is used.

Descriptions of Housing and Support Types

Locke et al. (2007) have identified that the range of options that are available to homeless people consists of:

- Emergency housing, including shelters, hostels, drop-in centers and other forms of crisis accommodation, often in a group setting. Services vary from intensive case management to a minimum of information and referral assistance.
- Transitional housing, including short-term stay lodges, group homes, shelters, halfway houses and other temporary accommodation. Housing is usually offered for longer terms (i.e., six months to two years) often in single dwelling units or in small group settings with available programs and services.
- Permanent housing, including apartment units, townhouses, group homes and single-family residences that are either rent-subsidized and leased in the open market or long-term, set-aside units in privately owned buildings. Permanent supported housing is often targeted to people who have disabilities, including mental illness and substance abuse issues, and programs and services are offered either by the operator of the housing or in partnership with service providers in the community.

(Dolan & Hughes, 2011)

Note: further information on types of support for housing can be found at:

<http://www.endedmontonhomelessness.com/about-homelessness/glossary.aspx>

Recovery-oriented residences (Fisher, 2012)

There are residences that adhere to recovery principles, particularly in the U.S. As with most housing with supports, the classification of this housing needs standardization and the following was one way to define the levels of intensity. This new residential matrix was designed to afford those seeking recovery residences the ability to select the modality that best fits presenting needs.

Level 1: Peer-Run

Level 1 recovery residences offer housing with supports in a peer environment. These recovery residences are often referred to as “sober homes,” and are most often found in single-family residences. Oversight of residents is peer-based; residents are self-monitoring and accountable to one another. Oxford Houses are the most commonly known example but there are many other peer-based and democratically operated sober homes throughout the country.

Level 2: Monitored

Level 2 residences are characterized by peer-based recovery support services overseen by compensated peer staff. These homes utilize a senior resident or a house manager who monitors operations and residents, enforcing structure that is implemented in the form of house rules. There is an emphasis on community and accountability that manifests in a culture of peer support.

Level 3: Supervised

Level 3 recovery residences offer peer-based residence plus extended-care programming with an emphasis on life skill development, overseen by professional staff. Guidance is provided toward the establishment of life and recovery sustaining activities (i.e., employment, self-help, physical health, etc.). Case management and clinical services are contracted in or accessed in the outside community. On-site staff promotes and sustains the recovery environment. Average stays vary from 90 days to a year or more.

Level 4: Service provider

This type of recovery residence provides peer-based services plus life skills, and clinical programming. It is most often aligned or attached with a licensed treatment provider, and overseen by an appropriately credentialed and qualified management team. This level is characterized by a high degree of daily structure. Licensed and credentialed staff members provide in-house program services.

Leff (2009) defined four types of housing for the purposes of analysis and comparison:

- Residential care and treatment model housing
 - “High demand” environments, where privileges and rules of conduct are well defined, participation in services (some delivered in the housing) is required, and abstinence from alcohol or other drugs is a prerequisite
- Residential continuum model housing
 - “High demand, high readiness”; residents must comply with certain conditions including accepting treatment and they must demonstrate “readiness”, usually defined by professional clinicians; participants move through a ‘continuum’ as they achieve more stability of symptoms and independent living skills
- Permanent supported housing model
 - Low demand, services and supports are introduced as needed and there are no conditions of treatment (some may have expectations of abstinence)
- Non-model housing
 - Any other form of housing – utilized in research paradigms as “treatment as usual”; no supports or services to find and obtain housing

In their meta-analysis (Leff, 2009), housing models were always superior to non-model housing in the stability of housing outcome. Permanent supported housing was superior to all others in resident satisfaction. The researchers also found that housing models provided the preconditions for other outcomes such as engaging in treatment, skill building, and community integration.

The traditional concept of a housing continuum focuses on “graduating” households through the system, ultimately to permanent housing. The definition of permanent housing may vary depending on the household and need. For some people, permanent housing may include homeownership while for others it may be comprised of a congregate living situation complemented with support services (Collaborative Solutions Inc, 2008).

Provision of housing is clearly insufficient to address the problem of homelessness and the traditional approaches have presented significant difficulties. People reported they were unable

to access the services they need for many reasons, including:

- Supports not being portable whereby moving can result in a loss of support
- Eligibility restrictions on services (i.e., exclusion due to physical health problems or involvement with the law)
- Distance and location of services
- Full caseloads among clinicians

(Mental Health Commission of Canada, 2010)

In light of the lack of available resources, rural service providers must be creative when planning permanent housing with supports developments. This means knowing the other service providers in the area and developing potential partnerships that can lead to successful projects. It means working with local governments to access funding for a project that an organization cannot access otherwise. And it usually means creating a smaller numbers of housing units because they will cost less and fit in better with the community than trying to construct a 75-unit building (Collaborative Solutions Inc, 2008).

Characteristics	Housing Approaches		
	Custodial Housing	Supportive Housing	Supported Housing
Typical Settings	<ul style="list-style-type: none"> • Board & Care Homes • Foster Families 	<ul style="list-style-type: none"> • Group homes, halfway houses, clustered apartments 	<ul style="list-style-type: none"> • Independent Apartments
Role of Consumer	<ul style="list-style-type: none"> • Patient 	<ul style="list-style-type: none"> • Resident 	<ul style="list-style-type: none"> • Tenant, Citizen
Role of Staff	<ul style="list-style-type: none"> • Care Provider 	<ul style="list-style-type: none"> • Rehabilitation Agent • Residents have little control over where or with whom they live. 	<ul style="list-style-type: none"> • Facilitator
Locus of Control	<ul style="list-style-type: none"> • Staff control 	<ul style="list-style-type: none"> • Resident has little control over services they receive; potential for shared control over household decisions 	<ul style="list-style-type: none"> • Consumer control
Nature of Intervention	<ul style="list-style-type: none"> • In-house staff provides care services 	<ul style="list-style-type: none"> • In-house staff provides rehabilitation services 	<ul style="list-style-type: none"> • Staff from outside provides supports that are consumer controlled and individualized.

(Source: Nelson, Geoffrey 2010 – Adapted from Parkinson, Nelson and Horgan, 1999)

Studies Comparing Supports or Interventions in Permanent Housing

Clark and Rich (2003) found an interaction between type of intervention and level of client impairment. Clients involved in the housing intervention and case management intervention attained better housing outcomes.

Those studies that demonstrated a decline in housing retention over time seemed to suffer from the same problem: lack of consistent and intensive case management for a large percentage of their study cohort. Intensive case management is needed to maximize housing retention and stability among this population (Center for Psychiatric Rehabilitation, 2008).

Participants in one study of the impact of housing interventions who were recruited from the streets showed greater reductions in days spent homeless than those recruited from hospitals (Gulcur et al., 2003).

Many authors noted the tensions between treatment first (preferred by clinicians) and housing first (preferred by clients). The vast majority of the literature states that the treatment of substance use and mental disorders cannot be meaningfully considered in the absence of appropriate housing:

- Service providers encounter great difficulty engaging mentally ill people who are living on the street
- A large majority of the studies reviewed so far state that outcomes have shown program elements are the primary variable in accounting for housing retention – that any individual can hold tenure in the community with the right supports. (Tsemberis & Eisenberg, 2000)

Permanent Supported Housing (PSH) models vary according to the following dimensions:

- Affordability: There are variations on the degree of affordability within a PSH model. In Canada, the rent levels are most often set at 30% of the household's gross monthly income.
- Access: Different PSH models use different methods to determine who will have access. In some cases, individuals self-select as likely candidates, whereas other models employ assessment or decision making tools to screen candidates.
- Concentration: In some models, PSH is a multi-unit residential building where all tenants have access to the supports. Others use scattered site models and congregate living models, head-leasing or single-family homes and townhouses.
- Building design and density: The experience of tenants is impacted by a number of factors including size of units, density of building, number of floors, shared accommodation, amount of shared space, etc.
- Support service delivery: While all PSH has supports—hence “Supported Housing”—there are no existing standards about the type, intensity, duration or frequency of the supports. Further, there is no standard about whether the supports are delivered by the operator of the housing, sub-contracted or brokered to the facility.
- Relationship with community: Different degrees of engagement with the community are possible, ranging from minimizing the visibility of the project to active involvement of community and even businesses.
- Specialization: Some projects target specific populations or specific gaps in services such as harm reduction approaches. (KPMG and OrgCode Consulting, 2011)

Housing First

Housing First is an approach that has gained credence over the last ten years. First researched in New York, this refers to the provision of permanent housing with support without the requirement that homeless individuals accept treatment or have stabilized. Individuals for whom rehabilitation or treatment have been unsuccessful can be housed and the outcomes for this well-researched paradigm have been consistently positive (Tsemberis & Eisenberg, 2000).

This paradigm challenged the assumptions of traditional approaches that have roots in the institutional model of treatment. In that model, it is assumed that people need to learn independent living skills and address behavioural issues that have interfered with their stability in the community. This makes some logical, if linear, sense and most service providers are familiar with this approach and have designed their programs and trained their staff in this system of care. However, after several years of study, the Housing First program in New York City [Pathways to Housing, described in detail in the jurisdictional review section] sustained an approximately 80% housing retention rate, a rate that presents a profound challenge to clinical assumptions held by many Continuum of Care housing providers who regard the chronically homeless as “not housing ready.” More important, the residential stability achieved by the experimental group challenges long-held (but previously untested) clinical assumptions regarding the correlation between mental illness and the ability to maintain an apartment of one’s own (Tsemberis, 2004).

A key component to the Housing First support system, formalized by the Pathways to Housing study, is the Assertive Community Treatment [ACT] team. ACT programs target individuals with severe mental illness who do not respond well to less intensive modalities and/or who are frequent users of social and health services. ACT services adhere to essential standards including multidisciplinary personnel, medication monitoring and small client to staff ratios. Interchangeable roles [people are clients of the team, not of a single case manager] ensure that services are not disrupted by staff absence or turnover. Services are provided within community settings and are intended to be available long-term (Stein & Test, 1980) (Coldwell & Bender, 2007).

In a review of variants on the Housing First approaches in the U.S., several program components emerged consistently as important contributors to success despite differences in the overall models. While the programs varied in areas such as congregate or dispersed housing, on-site or remote staff, abstinence requirements, the following were essential features:

- Access to a substantial supply of permanent housing
- Providing housing that clients like
- Wide array of services to meet the multidimensional needs of clients
- Service delivery approach that emphasizes community-based, client-driven services
- Staffing structure that ensures responsive service delivery, including access to multidisciplinary staff, regardless of case management model
- Diverse funding streams for housing and services

(Pearson et al., 2007)

There were two other “Housing First” approaches developed in disparate locations; one in 1976 in Toronto, Canada (Houselink) and one in 1988 in Los Angeles (Beyond Shelter). These

innovative approaches were not researched and there is some speculation that they were responding to client needs and principles of recovery and psychosocial rehabilitation. (Waegemakers-Schiff & Rook, 2012)

Houselink emerged from this need and included the principle of an ‘intentional community’ as part of its approach. Its success has been reported but, as with many pioneering initiatives in the community, there are no quantitative studies to support its narrative of success. This is part of the dilemma in the Housing First literature and in the housing and supports literature overall. Pathways to Housing has been rigorously studied but its population is primarily single adults with no dependents and the results may not address the efficacy of Housing First approaches for other homeless and high risk groups. (Waegemakers-Schiff & Rook, 2012)

Staircase or Continuum or Linear Models

In contrast to Housing First, programs that move stepwise from rehabilitation settings to permanent domicile are known as linear approaches. Linear approaches have different designs and theoretical underpinnings, which usually reflect theories of human behavior change. Most linear interventions assume that a return to long-term stable housing, in either the private market or a subsidized setting, requires the restoration of behavioral self-regulation and the capacity to interact in a constructive social environment and also that an individual’s tangible resource needs must be addressed in order to ensure that person’s engagement and attendance (Kertesz S, 2009). Housing is seen as one of the outcomes of rehabilitation.

The Continuum of Care approach has had limited success and has been criticized for several reasons (Tsemberis, 2003; Dixon & Osher, 1995; Gulcur, 2003) including:

- Difficulties in engaging individuals;
- The requirement that individuals change housing as they “progress” through the continuum may be counterproductive, even causing symptomatic relapse;
- Clients prefer to live in independent housing and have complained about the institutional qualities of many treatment-oriented housing settings;
- Client choice or preference may be ignored;
- Skills learned for successful functioning at one type of residential setting are not necessarily transferable to other living situations;
- It takes a substantial amount of time for clients to reach the final step on the continuum;
- Individuals who are homeless are denied housing because placement is contingent on accepting treatment first;
- Given the lack of data on how rapidly individuals should progress through the phases, time limits may seem arbitrary and a step-wise progression may not mirror the client’s clinical course.

(Dixon & Osher, 1995; Tsemberis & Asmussen, 1999; Tsemberis et al., 2003).

The “housing first” approach is an alternative to the continuum of care: housing is viewed primarily as a place to live, not to receive treatment. Central to this idea is that clients will receive whatever individual services and assistance they need to maintain their housing choice. Proponents of this approach emphasize that it facilitates normal community roles, social integration, and increased independence and control for the client.

In comparative trials, well-resourced Housing First programs produce better housing outcomes compared with unspecified aggregates of unknown community-based rehabilitation programs, at least for persons with severe mental illness. The finding that substance misuse was no worse in New York's Pathways to Housing group (compared with a linear model control), led the study's authors to question the utility of requiring sobriety or treatment (Tsemberis et al., 2004). Generalizing these results to all chronically homeless, however, could be inappropriate, given what appears to be the relatively modest average addiction severity of clients entering most Housing First programs.

HOMELESSNESS

People who are homeless generally share a number of experiences and characteristics that make their needs for housing with supports different from those of the general population. The severity, type and number of issues they acquire is impacted by the length of time they are homeless, the number of times they have been homeless, and whether they have been sleeping rough, frequenting emergency shelters, living in a place not meant for human habitation, staying with friends and family (couch surfing), or a combination of these situations. Service providers and formerly homeless research participants speak of the critical need for supports and services provided in conjunction with housing to be sensitive and responsive to the residual effects of the traumatic events experienced while homeless (McDonald et al., 2009).

General homeless population

Population Profile

The literature indicates that regardless of their paths into homelessness, people who are homeless tend to share at least some of the following general characteristics:

- Addictions/substance abuse;
- Mental health issues;
- Chronic physical health issues: back, foot, arthritis/joint problems, migraines, respiratory illness;
- Acquired brain injury or other cognitive disability i.e. Fetal Alcohol Spectrum Disorder
- Learning disability;
- Low level of education and low literacy;
- Low self-esteem;
- Apathy, sense of futility, and low sense of control over their own lives (personal agency);
- Unemployment;
- Low income;
- Involvement in criminal justice system and/or incarceration;
- Victimization including robbery, assault, verbal threats, sexual assault. Those without shelter are more likely to be victimized, and more likely to engage in survival crimes;
- High levels of distress consistent with moderate to high suicide risk;
- Distrust of the system of services and supports;
- Loneliness and disconnection; lack of trust and inability to build relationships;
- Low life expectancy: a four-year study of 9,000 homeless people in Toronto demonstrated that the average lifespan was 46 years. A study in 2000 found that homeless males in Toronto were nine times more likely to be murdered than the general population.

(Brassard and Cousineau, 2000; Fischer, 1992; MHCC, 2012; Falvo, 2003; Tremblay, 2009; Roebuck, 2008; Novac et al., 2006)

Within a short period of becoming homeless, individuals learn, internalize, and assimilate a very specific 'street culture'. Adherence to this culture (which includes unwritten codes of conduct, values, and rituals) is necessary in order to survive on the street. Homelessness disrupts important social bonds and impairs personal networking that could be instrumental in getting off the street (Roebuck, 2008). Friends in the mainstream are replaced by homeless friends,

reinforcing and normalizing the homeless culture in their lives (Tremblay, 2009). Once internalized, this street culture becomes a “way of life” that may keep individuals entrenched in homelessness. Interactions with a public that “expects” certain behaviour from homeless people based on stereotypes further solidify role identification as a homeless person. The longer one remains homeless and on the street, the more risky their lifestyle becomes (Tremblay, 2009).

Challenges Faced in Making the Transition to Being Housed and Staying Housed

For homeless people, the transition from the streets or shelters usually requires significant adjustments in routine and lifestyle. Making new friends, paying bills, adhering to schedules and rules, and becoming familiar with a new neighborhood are some of the many adjustments that most individuals will have to make. Some people who have been homeless for extended periods of time may have developed behaviours that served them well on the streets, but are no longer necessary once they are housed. Examples may include hoarding, sleeping during the day and staying awake at night, or failing to bathe as often as necessary (Hannigan & Wagner, 2003).

Long-term homeless people, rough sleepers and those staying in shelters may feel great discomfort in their new housed lifestyle because of the extreme difference from what has been their normalized street-entrenched life. They can feel very disoriented, displaced and even trapped, to the point that they may consider returning to the familiarity of life on the streets. They may also feel overwhelmed by the sense of responsibility entailed in being housed (Brown, 2004). Their long-term sense of impermanence often continues even though they are housed, especially if they have experienced numerous failed attempts at attaining and retaining housing in the past.

In some cases, homeless individuals will have an issue with claustrophobia or other disorders that prevent them from being indoors. Others will have become so accustomed to sleeping outside that they have great difficulty sleeping indoors, and can only make the adjustment by sleeping part of the time outdoors or on a balcony (Carter, Friesen, Polevychok, & Osborne, 2007). Undiagnosed or latent conditions that occurred during homelessness affect health and well-being long after they move into housing (McDonald, Donahue, Janes, & Cleghorn, 2009).

Several studies refer to “homeless effects”, a lingering trauma adversely affecting mental health and self-image and exhibited in maladaptive responses such as self-isolation, disconnection and distrust of others - especially those who are part of the “system”. Barriers to re-housed individuals’ capacity to “get connected” or engaged in becoming and staying housed can be the internalized stigma and shame many participants feel due to their homeless experience, their receipt of income assistance, the depth of their poverty, and their residence in social housing (McDonald et al., 2009). Previously homeless research participants stress that recovery from the experience of homelessness was ongoing, and that one year of homeless experience requires several years of stable housed experience to heal (McDonald et al., 2009). Being sensitive to the enormous disruption experienced by people when they move into housing after being homeless is critical to the individual making a successful adjustment to being a new tenant. It is important for the staff to understand the reasons why people acquire certain behaviours when they are homeless (Hannigan & Wagner, 2003).

Overcoming Challenges through Housing with Supports

The literature is overwhelmingly in agreement that homeless people have greater success maintaining housing stability when appropriate supports are provided along with housing, as compared to housing alone. There are many forms in which these two elements can come together for positive client outcomes. The most common models of housing with supports for homeless people are examined below, along with the ability of particular elements to respond to people's experiences of having been homeless, and the challenges they face in transitioning to being housed.

- **Challenge: Social Isolation, Lack of Normalcy and Temptation to Return**

For re-housed clients who are working on addressing behaviours linked to homelessness, it is often necessary to sever social ties linked to those behaviours in order to avoid situations which would make them vulnerable to slipping back into unhealthy lifestyles (Novac, Brown, & Bourbonnais, 2009). In a 2011 Soles and Co. survey of 121 clients from 12 homeless-serving agencies in Edmonton, "almost all of the clients, regardless of gender, age or race, identified living away from the downtown scene and having easier access to jobs, clean and safe housing as a preference in their lives."

However, supported housing for homeless people is often located near the supports and services they rely upon, which are generally concentrated in high-risk areas. Locating housing for recovering individuals in geographic areas that are less vulnerable to cyclical homelessness may result in diminished accessibility to important social supports. Whether in scattered sites or congregate housing, easy access to public transit is crucial (Kraus et al., 2005; Tremblay, 2009).

Some forms of housing with supports involve the sharing of living and sleeping space with strangers. While, on one level, living with others may present opportunities to develop friendships and extend social networks, the reality revealed in many research studies was exactly the opposite. Re-housed individuals often retain their distrust and fear of others, and those in recovery can also experience anxiety around the potential of recidivism through sharing space with others in recovery. Although tenants have indicated that the clustering of people with similar challenges promotes greater understanding and acceptance, they also feel it can create "dangerously vulnerable and disadvantaged housing communities" (McDonald et al., 2009). This adds an additional layer of self-protective behaviours that further undermines feelings of safety and belongingness. In some cases, the experience of sharing accommodation is so repellent that some people return to the streets (Anucha, 2003). Staff in congregate housing, on the other hand, have been found to value opportunities for regular informal contact with clients. They reported that it promoted trust-building, and encouraged a shared feeling of community among staff and clients, which in turn encouraged the use of support services to enhance recovery (Johnsen & Teixeira, 2010).

When given the option, studies have shown that most homeless individuals express a clear preference for self-contained units, and feel that diversity of age, gender, ability, health and mental health status and of tenure (i.e., mixed subsidized and market rentals) prevents "ghettoization" (McDonald et al., 2009) (Anucha, 2003). Living in self-contained units also enhances a sense of self-determination and normalcy.

Scattered independent units with wrap-around supports (Housing First) have been successful in removing re-housed individuals from environments that put them at risk of recidivism; however, residents often feel isolated and lonely and may return to the streets as a result (Dinning, 2008; McDonald et al., 2009). Studies have indicated this can often be prevented through the development of strong relationships with support workers who are available “24/7” (Anucha, 2003; McDonald et al., 2009; Novac et al., 2009).

An over-emphasis on providing supports with measureable outcomes, such as employment, along with a lack of supports for social inclusion left more than half of one study’s participants in Toronto and Edmonton feeling dissatisfied with their lives once housed (McDonald et al., 2009). Discrimination, internalized stigma, and lack of opportunities for meaningful participation were identified as key barriers to social engagement within their communities (McDonald et al., 2009). Whether in scattered sites or supported housing, community building approaches which emphasize inclusion, valuing peer knowledge and participation in decision-making (i.e. self-regulated housing) best address social isolation and safety issues, while enhancing individuals’ sense of personal agency (McDonald et al., 2009).

- **Challenge: Apathy, Sense of Futility, Low Self-esteem, Self-doubt and Low Sense of Personal Agency**

Numerous studies have found that increased choice in housing is related to positive housing outcomes (Dinning, 2008; McDonald et al., 2009; MHCC, 2012; Kraus et al., 2005). It fosters a sense of personal agency and self-esteem, which extends to other aspects of life. Preliminary findings of the Canada-wide Chez Soi initiative indicate that offering a broad range of appropriate options allows for selection of the most suitable type of housing. This involves expanding the options beyond scattered-site units to also include supportive, social, shared or congregate housing options for those who would prefer these. Narrative interviews suggest that the latter options may be preferred by individuals concerned about isolation and/or having very high support needs (MHCC, 2012).

In addition to providing housing choice, a comprehensive, positive client-directed approach to supports has been found to be key in building self-esteem, reducing self-doubt, apathy and a sense of futility, and increasing a sense of self-determination (Kraus et al., 2005; McDonald et al., 2009; Dinning, 2008). These outcomes can be further enhanced by informal or formal involvement of formerly homeless individuals in the decision-making and management of their housing residence, which also promotes integration and reduces isolation (Dinning, 2008).

While employing a harm reduction approach and upholding the value of choice over treatment and support options, the Chez Soi report emphasizes that allowing participants to direct their treatment does not imply a laissez faire approach to engaging participants: “We have learned that people are more likely to successfully maintain their housing if they are engaged with their service teams” (MHCC, 2012). This can mean integration of motivational approaches and alternative illness management in day-to-day practice, especially regarding challenging behaviours that could strain landlord relationships and jeopardize housing.

- **Challenge: Feeling Trapped, Unsafe and Uncomfortable**

Researchers have found that treatment strategies have little or no effect or are declined by clients unless they feel safe in and satisfied with their residential programs (Brown, 2004).

Shared accommodation and housing located in crime-ridden areas can lead to tenants feeling unsafe and ill-at-ease. A lack of access to public transit, or unaffordable transportation costs can make people feel trapped, as can personal limited mobility, and/or the imposition of rules that limit independence (McDonald et al., 2009). Access to secured outdoor space, even as little as a balcony can ease a sense of feeling trapped by offering the option of sleeping outdoors for those who have difficulty adjusting to living and sleeping indoors.

Some studies have found that the immediate sense of isolation, loneliness and displacement when housed in permanent, independent apartments may lead to decreased functioning in some respects for some people and, in some cases, increased substance abuse (Dickey et al., 1996). These studies have, therefore, recommended the use of the linear housing continuum model to help ease the transition to independent housing (Brown, 2004). However, numerous other researchers, including members of the National Association of State Mental Health Program Directors (NASMHPD), have expressed a belief that the residential transitions of the continuum model may disrupt clients' social relationships and sense of stability, hamper living skills gains, and decrease success by usurping clients' perception of freedom and dignity (Brown, 2004).

- **Challenge: Sense of Impermanence/Instability - Housed, But Still at Risk of Homelessness**

A history of housing instability can make newly re-housed people feel insecure about their housing status, an issue that sometimes can only be solved with time. The sense of instability and impermanence can result in difficulty making long-term decisions or committing fully to a process of recovery. The temporary nature of transitional housing can exasperate this. Being precariously housed in an unsafe, inadequate, or unsuitable situation can cause great anxiety about whether it is better to be poorly housed or homeless. This is an unproductive state of limbo. Living in unaffordable housing can keep residents in extreme poverty, having to choose between paying rent and eating, and in a constant state of anxiety about losing their housing again (McDonald et al., 2009).

- **Challenge: Losing Housing**

By "de-linking" housing from supports, Housing First programs can target individuals who have declined rehabilitative treatment or for whom treatment has been unsuccessful (Kertesz S, 2009). They can become housed without committing to treatment, and they can lose their housing without jeopardizing their supports. Research studies have found that staying connected to residents and coordinating their supports can be more difficult when housing and support service providers are not part of the same organization (Dinning, 2008). In some cases, there have been tensions around who ultimately makes decisions (housing or clinical team). There also may be a tendency to use re-housing as a strategy to address a difficult situation. One Chez Soi project was seeing a high rate of housing loss by re-housed program participants because the support workers were not initially made responsible for participants' housing stability. Once support workers were given responsibility for ensuring that participants remained housed, recidivism dropped significantly.

Reasons that a participant might be re-housed include that the participant is being evicted or is at risk of eviction, they have been hospitalized or incarcerated, or they request a move if their current place does not meet their needs (MHCC, 2012). Evictions or the risk of evictions are a

common reason for re-housing and can be challenging, particularly when it involves multiple evictions or moves for one participant (MHCC, 2012). In smaller communities, the word about particular housing challenges of an individual may spread among landlords, making it extremely difficult to find housing for that person again.

In the Chez Soi initiative, service teams work with participants to learn from each re-housing event, whether it is as a result of evictions or participant choice. As much as is possible, participants are involved in the move and in some sites, participants contribute towards their moving costs (MHCC, 2012). Including supportive housing as an option, however, does not alter the need in principle to maintain separation of the housing and support aspects of the Housing First model. The question then is how can a congregate model continue to provide housing and support for a resident requiring re-housing (MHCC, 2012).

The Chez Soi initiative, at the time of the interim report, had a small group of participants (approximately 11%) for whom housing had not worked at that time. Reasons for this include that the participants were no longer interested in being housed, were not available to be housed (moved to another city, were incarcerated or hospitalized) or that they felt that the housing did not work for them after trying it out (MHCC, 2012).

Is there a Role for Transitional Housing for Homeless People?

Achieving “housing readiness” is the underlying goal for all transitional housing programs; however, there is substantial debate surrounding the appropriateness of this goal for all groups and the validity of the assumption upon which it is predicated.

Much of the research argues that these programs can only succeed if appropriate and affordable permanent housing is available upon completion of the transitional period (Barrow & Zimmer, 1999; Fogel, 1997; Nesselbuch, 1998; Novac et al., 2009). Critics suggest that transitional housing siphons off monies that could be better spent supplying permanent affordable housing (Barrow & Zimmer, 1999). On the flip-side, however, the REACH report indicates that in the absence of readily available permanent housing, 24-hour interim housing that provides counseling, encouragement and housing assistance is necessary for clients when they are ready to make new beginnings. For clients leaving incarceration, addictions treatments, hospital and mental health institutions, living on the street or in emergency shelters puts them at risk of sliding back into old habits and familiar lifestyles (Soles and Company, 2011).

Transitional housing is an intermediate step between emergency crisis service and long-term permanent housing. Building form and living arrangements range and include dormitories, shared rooms with common facilities, single-room-occupancy hotels, and dedicated apartment buildings. It is more long-term, service-intensive and private than emergency shelters, with limits on length of residence of between three months and three years (Barrow & Zimmer, 1999). As residents become stabilized, the program is expected to help them find permanent housing (Novac et al., 2009). Assertions that long-term transitional housing creates program dependencies are most strongly targeted at those programs clustered around the high-demand end of the spectrum (Fotheringham, Walsh, Burrowes, & McDonald, 2011).

At one end of the transitional range is housing that makes retention contingent on adherence to rules and mandated participation in program activities, whereas other low-barrier transitional

housing programs strive for flexibility through allowing optional program activity attendance and few regulations. Barrow and Zimmer also found that transitional housing programs vary in terms of the subgroup of the homeless population they target, physical structure type, level of privacy, location, and admission criteria, all of which work together to influence and shape program outcomes.

This substantial variation in transitional housing approaches complicates efforts at conducting an overarching evaluation, which is further confounded by the use of highly ambiguous outcome terms such as “housing success”, and by high attrition rates that can result in data collection from only the most motivated clients who remain in the program. In addition, there has been a lack of long-term or follow-up evaluations of transitional housing beyond a 12-month period (Fotheringham et al., 2011).

This makes any definitive analysis as to the success of transitional housing problematic. However, it is generally agreed upon that:

- 1) People who are most likely to benefit from transitional housing include those who are recovering from traumas; lack social networks; have a background of multi-generational poverty; are exiting institutions without independent living skills; need skill training in order to obtain a living wage; have mental health problems; are attending addiction treatment; are physically or mentally disabled; or are recent immigrants (Novac et al., 2009; Fotheringham et al., 2011).
- 2) High-demand or highly structured transitional facilities which double as treatment programs for people with severe mental illness and/or addictions appear to improve housing and clinical outcomes for participants who complete the programs, but such programs have extremely high attrition rates and are not an effective route out of homelessness for most people (Novac et al., 2009).
- 3) Models emphasizing transition may marginalize or adversely impact those persons who cannot or will not make those transitions. This suggests that client-centred, flexible models would be able to accommodate both the option to stay permanently, and the option to move on to more independent living.

Homeless Sub-populations

The general profile of the homeless population provides an overview of commonly shared characteristics and challenges. The homeless population is not homogenous, and is composed of a number of sub-populations, each with unique characteristics and challenges that make their housing and support needs different from those of the general homeless population. There are important differences across subpopulations with respect to the housing and service arrangements that are associated with successful housing outcomes.

Understanding these is crucial to ensuring that members of these sub-populations are receiving appropriate services and supports. This does not negate the fact, of course, that the homeless population is composed of individuals, each with their own particular sets of strengths, experiences and challenges that are also important to understand in further targeting housing with supports. Effective programs are those designed for particular sub-populations and are flexible enough to target the particular needs of individuals and enhance their strengths. The following section considers a number of key homeless sub-populations. This is not an

exhaustive list, and these sub-populations are not mutually exclusive: an individual could fall within any number of these sub-populations simultaneously.

Homeless Youth

Population Profile

Youth are one of the fastest growing groups among Canada's homeless population and are becoming the face of poverty, as illustrated by national trends showing that poverty is affecting a younger demographic (Asher, 2007). As with the general homeless population, the vast majority of homeless youths' experiences include mental and physical health issues, low level of educational attainment, unemployment, victimization, low-self-esteem, distrust of "the system", substance abuse and involvement with the justice system. The homeless youth sub-population has a high mortality rate, with suicide as the leading cause of death. As with adults, the longer youth remain homeless, the worse their health and life chances become (Raising the Roof, 2009) (Kidd, 2009).

In many ways, however, street-involved youth have very different experiences of homelessness than do adults. The gender distribution among homeless youth is distinct from that of adults; unlike older homeless people, girls are strongly-represented among homeless youth (Serge, 2002). Youth are in a vulnerable and impressionable stage of development and lack life experience, which puts them at high risk of exploitation by adults. In response to promises of support and stability, or out of sheer desperation, homeless youth may resort to prostitution or survival sex with adults (Kidd, 2009).

Homelessness also looks different for youth in urban centres compared with those living in rural areas. Much of the research conceptualizes youth homelessness as an urban problem. Estimates are virtually absent for youth who experience rural homelessness and for estimates that do exist, they reflect its invisible nature. "This exclusion has significant implications in that it marginalizes the rural homeless and hinders the development of social policy to address the issues that this population faces" (Skott-Myhre, Raby, & Nikolaou, 2008). Although it is believed that youth have the option to migrate to urban centres for services, Skott-Myhre et al. (2008) have shown that this is not ideal. In doing so, youth have to leave behind their network of informal social supports and their sense of community.

Youth are also vulnerable to exploitation by their peers, who figure prominently in their lives and to whom they look for acceptance. As is common with most young people, homeless youth have difficulty saying "no" to peer group pressure, which can lead to being taken advantage of. Youths' street communities are fleeting, lacking in supports or sense of belonging. A lack of relationships and isolation are significant factors in the lives of homeless youth. They themselves identify their need for relationships as of primary importance. Though family conflict plays a pivotal role in youth homelessness, continuation of family relationships is important to them (Kidd, 2009; Serge, 2002).

Adolescence and young adulthood is a developmental stage of life in which youth learn social norms, coping skills, appropriate behaviours, life skills and what it means to be an adult. This process involves a lot of trial and error as they "try-on" different identities. Youth need to be

able to experiment with opportunities and to be able to fail and try again in a supportive environment. In the absence of a stable home-life, strong adult role models, or a supportive environment, the consequences of making mistakes can be life-altering. Survival on the street becomes the extent of the life skills they learn, making it difficult for them to understand and function in mainstream society.

In general, the public has a distaste and profound lack of respect for homeless youth. The general assumption is that homeless youth are runaways who left because they didn't like the rules of regular family life. The idea of street life as a choice is a fallacy – "homeless youth are running away from something, not towards street life." Rarely can you find a homeless youth who has experienced a stable home life. The fact that they choose the incredibly unstable, complicated and dangerous life of the streets is evidence of how they "have been completely ravaged in their families" (Karabanow et al., 2011; Gaetz, 2012). For those who leave their family homes, they lose not only shelter, but also their supports and all that is familiar and become exposed to all the dangers from which the family is supposed to protect them (Serge, 2002).

Many other youth are homeless due to failures in the child welfare system, leaving them fearful of a system that was meant to support them. Homeless youth often try to "fly under the radar" so the system or their family cannot return them to the experiences they escaped. They are generally unemployed and, in staying out of the system, do not receive government income supports. They resort instead to high-risk activities in the informal economy such as prostitution, drug dealing, squeegeeing or panhandling. Because this survival work is criminalized, youth become further marginalized by "the system." Most homeless youth do not have identification, which means they cannot access healthcare. Undiagnosed and untreated health issues are worsened by lack of sleep, poor nutrition, repeated injuries and their inability to maintain good hygiene.

As youth become entrenched in homelessness, they lose ties with the education system quickly as well. Attending classes and completing school work can be very difficult for someone living on the street, even in cases where youth want to continue their schooling. The first few weeks of homelessness are a critical window of opportunity for intervention and preventing long-term entrenchment.

Despite the numerous issues youth face when homeless, they are incredibly resilient and creative. They build street families, develop street moneymaking economies, street housing and street routines, all while being marginalized, harassed and excluded (Raising the Roof, 2009). Homeless youth are generally hopeful for their futures, have plans for family, partners, employment, and stable homes. Travel is a big part of the lives of homeless youth. They travel in search of better supports, in search of better communities and to escape dangerous environments. Youth often have pets for protection, companionship, and shared body heat in cold weather. In return, pets help youths shape a more healthy understanding of who they are (Karabanow et al., 2011; Gaetz, 2012).

Housing with Supports for Homeless Youth

Research indicates that traditional homelessness services and substance abuse treatment programs for adults seldom work for youth, for the following reasons:

- Line-ups for everything, a lack of choice, and getting kicked out during the day make youth feel more homeless by reinforcing their marginal status (Karabanow et al., 2011).
- Substance abuse treatment programs for adults that focus on abstinence lack an understanding of youth development.
- Addictions and mental health workers who do not have specific training/interest in the youth population come up against issues when they try to apply assumptions that work with adults.
- Youth may not be able to understand or relate to the treatment expectations and may end up being seen as non-compliant or resistant.
- Youth often fail to make the transition to independent living because of underdeveloped life- skills, inadequate education, and lack of supports and resources that most young people have learned while living with parents and rely on when moving into adulthood. Some youth 'age out care' without having been prepared for independent living (Gaetz, 2012).

Housing First, which places individuals into independent, permanent housing, has proven to be problematic for some youth because:

- 1) Youth are devastated if they fail;
- 2) Youth experience extreme loneliness because they have never lived alone before; and
- 3) They generally have not yet learned the life-skills ordinarily learned during teen years which are necessary to keep a place of one's own (Karabanow et al., 2011).
- 4) Even once they are housed, youths' dietary intakes and food deprivation generally does not improve because welfare for "single employables" is insufficient to cover basic costs.
- 5) Many youth find dealing with independent living and addressing substance use/addiction issues at the same time would be too much to deal with at once (Forchuk, 2011).

Successful physical, psychological, emotional and social transitions into adulthood require:

- Strong adult support (including mentoring);
- Opportunities to experiment and explore (and to make mistakes);
- Learning to nurture healthy adult relationships (including sexual relationships); and,
- The learning of skills and competencies related to living independently.

Unfortunately, when young people become homeless or are in crisis, many of these assumptions about adolescent development are abandoned in the rush to make them self-sufficient. Supports fail to recognize that there are major differences between a homeless 12 year old, 16 year old and 20 year old. Support for healthy adolescent development must be at the centre of any support system for young people leaving care and others leaving street life (Gaetz, 2012).

In addition to the above points, research indicates that effective housing with supports for youth exiting homelessness incorporates most/all of the following elements:

- Long-term intermediary housing options with in-house support to help youth transition;
- Stability and consistency in an environment that allows them to mature in a safe way;
- Supports to help youth fit in/belong; develop self-esteem, confidence and social ties;
- Harm reduction rather than the "just say no" approach (McDermott, 2007);
- Opportunities to talk freely about their use of drugs and other substances;
- A culture of hope and possibilities for the future;
- Compassion and emotional support (including individualized and unconditional attention);

- Limits to and consequences for their actions;
- Increased responsibilities and freedoms;
- Professional intervention opportunities – health, mental health, addictions, etc.
- Encouragement to continue education and employment readiness;
- Opportunities to build on existing strengths and talents. (Serge, 2002; Gaetz, 2012)

In order to meet the complex needs of young people leaving care, such a model should involve inter-institutional collaboration between the provincial government, child protection services, the transitional housing provider, mental health services and corrections, for instance (Gaetz, 2012).

Project size has not been found to be a factor, in and of itself, but project proponents in general seem to want to limit themselves in terms of the number of youth accommodated in one location. A smaller size is better able to replicate a home-like environment. An assessment of transitional housing projects for youth revealed that some, which were too large, had problems managing violence, vandalism and drugs, and were often too "institutional" (Serge, 2002).

Young people need homes, not just housing. In a recent research project consulting homeless young people in Calgary and area (age 12 to 17 years with an average age of 15.8 years) about their experiences with various programs and services, the majority expressed a central desire for housing options that are modeled on family-style placements (Calgary Homeless Foundation, 2011). Appropriate housing for young people exists on a continuum, incorporating various housing solutions that will respond appropriately to the broad range of the homeless youth's needs so youth can transition from one to the other according to their individual developmental assets. Housing within a continuum can take any number of forms including: shared independent housing (roommates), group homes with an on-site adult who acts as a house parent, scattered-site and independent apartments with any needed additional supports (Housing First option). The continuum allows youth to transition from one form of housing to another, according to their individual developmental assets. (Calgary Homeless Foundation, 2011)

LGBTQ Youth

LGBTQ (Lesbian, Gay, Bisexual, Transgendered, Transsexual, Two-spirited, Queer and Questioning) youth are overrepresented in the homeless youth population in Canada - around 25 - 40% of homeless youth versus about 5 - 10% of the general population identifies as LGBTQ. Compared to the homeless youth population overall, LGBTQ youth are more susceptible to developing mental health issues on the streets due to the stigmatization and unfair treatment associated with being a sexual and gender minority. Alarming high rates of depression, suicide, and suicidal thoughts have been reported by LGBTQ homeless youth (Abramovich, 2012).

The needs of transgender youth differ from those of LGB youth, whether they are homeless or not. For instance, needs may include transition-related surgery, hormones, name changes, and identification that matches their changed names. The complexity of these needs is exacerbated when one is homeless and does not have money, a health card, or a support network. Transgender youth face the highest level of discrimination of any other homeless youth group. Agencies serving homeless youth in Toronto have reported great difficulty in supporting transgender youth. Staff members tend to have minimal training around transgender-related

issues, needs, and terminology. Staff may not have an understanding of the importance of asking youth what pronoun they prefer, how they wish to be addressed, or that transgender people can also identify as heterosexual and do not always fit into the category of LGB (Abramovich, 2012).

Very little research has been done on this population, and there are few LGBTQ programs and services to look to for Best Practices. Ali Forney Centre in New York City has seen much success with its housing and supports for homeless LGBTQ youth. (See Appendix B for details) Ali Forney's service-delivery is/has:

- Trauma informed (i.e., "What happened to you?" versus "What's wrong with you?");
- Strengths-based;
- Holistic services (one-stop shop that supports the whole individual);
- Progressive threshold structure and prolonged engagement;
- Comfortable, slow-paced, rapport-building, non-judgemental;
- Staff represent a diversity of genders and orientations to provide solid role models;
- Identity affirming. (Shelton, 2011)

The importance of ongoing transgender-related staff training is fundamental to serving transgender youth in a respectful and supportive manner (Boyle, 2006). It is also recommended that housing provides private shower, bathroom and sleeping spaces. If housing is gender-specific, youth should have the right to choose where they wish to be, based on their gender identity, without further questioning or interrogation (Boyle, 2006).

Homeless Women

Population Profile

Research studies indicate there are a few key differences in women's experiences of homelessness compared to men's:

- Compared to men, homeless women use many informal strategies that render them less visible in order to avoid the increased physical and sexual danger associated with living either on the streets or in co-ed emergency shelters: these include becoming involved with men who have homes, exchanging housing for sex, remaining in abusive relationships, staying in unsafe and over-crowded housing, and sleeping in cars or couch surfing (Fotheringham et al., 2011; CERA, 2002; Walsh et al., 2010; Wenzel et al., 2000).
- Offensive comments and insults directed at homeless persons are disproportionately aimed at homeless women who often receive degrading sexual comments and offensive sexual gestures (Roebuck, 2008);
- One study of homelessness and victimization found that, in the previous year, 43% of homeless women versus 14% of men had been sexually harassed; 21% of the study's homeless women reported being raped in the previous year; and one-third of homeless women reported experiencing major violence while homeless (Roebuck, 2008);
- Staying in homeless shelters while waiting for affordable housing is difficult for women who have histories of violent victimization, as the presence of men in co-ed shelters can be experienced as threatening and dangerous (Walsh et al., 2010).
- Women who are homeless are often accompanied by children, and the housing and supports they require differ as a result (Hulchanski et al., 2009).

- Men who are homeless or vulnerably housed are twice as likely as the general population to commit suicide; women are six times more likely to commit suicide (Research Alliance, 2010).

There is a dearth of reviews of recent research examining outcomes of housing with supports for homeless women in Canada. Findings of a 2011 research study in Calgary suggest that once housed, women need time to rest and recover emotionally from various traumas. Not only those who flee domestic violence, but women with other pathways into homelessness also require supported time to heal and recover. While permanent independent housing in the community may offer time, it offers limited opportunity for relationship building with other women with similar experiences, an important component that transitional supportive housing provides (Fotheringham et al., 2011).

The same study indicated that the Housing First model may not be the best option for homeless women due to that population's high prevalence rate of having been abused. Housing First is based on the assumption that once a homeless person is provided permanent, independent housing with supports, they will then be able to attend to higher level needs. However, the body of research indicates overwhelmingly that, above all else, homeless women and other survivors of abuse and trauma need privacy, control, and safety if they are to succeed in residential placements (Schiff & Waegemakers-Schiff, 2010; Tutty et al., 2009; Walsh et al., 2010; Walsh et al., 2009; Fotheringham et al., 2011). Unfortunately, in most permanent independent housing arrangements, residents have little control over who is allowed into the building, potentially leading to feelings of insecurity and fear for survivors of abuse and, in some cases, further victimization (Fotheringham et al., 2011). In another study, homeless women felt they would be safer in transitional housing and felt there would be someone close-at-hand to talk to if they didn't feel safe. However, a number of research projects on women's experiences with transitional housing indicate that most women residents found the rules to be too restrictive. They had traded safety and security for privacy and control.

Common themes that emerged in the research on transitional housing for homeless women included length of stay, assistance with childcare, education and training, emotional support and counselling, privacy/personal space, geographic location/accessibility, and quality of housing. Since, many of these factors are inter-related, making improvements in one area may mean trade-offs in another. This has led to a degree of contention surrounding the "correct" way to deliver services to women in transitional housing facilities (Novac et al., 2009). Although moving directly from homelessness to permanent independent housing may be effective for some homeless women, findings from this study demonstrate that this may not be the case for all. As the trajectories into homelessness are complex and diverse for women, so too are the pathways exiting homelessness (Fotheringham et al., 2011).

In a study of homeless women's experiences of pre- and post-shelter independent permanent housing, women were faced with trade-offs and compromises related to poverty: dangerous locations in exchange for affordability, poor physical conditions in exchange for lack of discrimination from neighbours and landlords. Although no longer living in a homeless shelter or on the street, they faced the same barriers of poverty, inadequate and unaffordable housing, discrimination, violence, and lack of access to childcare and other services, which caused them to become homeless in the first place (Paradis et al., 2009).

Homeless Families

Population Profile

Recent research on effective housing with supports for homeless families in Canada is sparse, so we look to sources from the United States. Differences in preventative government supports for families between the two countries may translate into differences in the characteristics of homeless families overall and the appropriate types of housing with supports. Research from the United States indicates that when compared to the general homeless population, homeless families are considerably less likely to report having substance abuse problems and some types of mental illness; a larger percentage of homeless families attribute homeless episodes to financial or housing problems; and, homeless families are overwhelmingly headed by women. Unlike the general homeless population, outreach services are not warranted for families because they are not reluctant to enter the homeless assistance network or to receive housing subsidies or support services (Gerber et al., 2008).

Research suggests that for families that become homeless due only to financial or housing problems, the contribution of services such as case management to housing stability is minimal, after subsidized housing and income support from welfare are taken into account. Housing subsidies alone help the majority of homeless families achieve stable housing (Gerber et al., 2008).

As with the general homeless population, housing subsidies in the absence of supports do not lead to successful housing outcomes for homeless families that have other barriers to housing stability. The following are elements of housing with supports that research has found to be effective for homeless families whose housing stability is impeded by mental illness, chronic physical issues, substance abuse, and/or family violence:

- Rapid permanent independent housing placement;
 - Putting housing subsidies and income supports in place;
 - Development of long-term housing retention plans by the family;
 - Health and social services for adults and their children;
 - Continuity in education for children; and,
 - Voluntary participation in wrap-around supports to address non-financial issues.
- All interactions are undertaken with “respect, to build resilience and recovery”, a strengths-based approach to working with homeless families in addressing immediate needs and resolving underlying conditions that can hinder residential stability (Building Changes, 2011)

A study was undertaken of seven types of programs in San Francisco that each contained the elements above, and included scattered-site units; buildings dedicated to homeless families; and “mixed” buildings housing low-income people, only some of whom had been homeless. Residents reported high levels of satisfaction with their living environments as well as with the services they received, and according to the researchers, no single model appeared to be significantly better than any other at helping tenants achieve the primary goal of housing stability, as long as the model succeeded in creating an atmosphere of respect and trust among tenants and staff and was able to provide the resources that tenants needed (Locke and O’Hara, 2007).

A 2006 study prepared by the National Center on Family Homelessness combined results from a number of studies of 13 permanent housing with supports programs for families, to identify client and program characteristics and client outcomes and to assess whether certain combinations of program characteristics are associated with improved client outcomes (Bassuk, 2006). Although the authors caution that the analyses are limited by inconsistencies in the data across studies, the high-control programs seem to have better reunification and self-sufficiency outcomes, but their attrition rates are high. By contrast, low-control programs may have higher residential stability but are not as successful at helping families reunify or move to greater economic self-sufficiency (Locke and O'Hara, 2007).

Unlike with adults alone, providers working with homeless families with violence, mental health, addictions and/or substance abuse issues must take into account the vulnerability, needs and safety of children in determining how “voluntary” participation in recovery should be. Further, when family reunification or preventing the loss of custody is a goal, parents need to show credible progress to the child welfare system (Locke and O'Hara, 2007).

Given the challenges of raising children while living in poverty or on low incomes, it is unreasonable to expect all families to become financially independent, but the evidence suggests that they can maintain permanent housing if it is affordable, and that permanent housing with transitional support services is more effective than transitional housing (Novac, 2009).

“Chronic” Family Homelessness—High Needs and Risk

Chronically homeless families, or High-Needs Families are those with not only a complex set of physical and/or behavioral health and/or social needs, but also have:

- High levels and lengthy involvement in the criminal justice system/child welfare system;
- Long-term substance abuse;
- On-going intimate partner violence;
- Multiple and extended periods of homelessness;
- High rates of change in family composition; and
- The parents may have first experienced homelessness as children or youth. (Building Changes, 2011)

This group has the highest rates of using crisis services (such as inpatient mental health or inpatient substance abuse treatment). The longer these families are homeless before entering transitional housing, the more likely they will not have their own place to live in the year following a “successful” exit. Chronically homeless families, however, often “blow out” of transitional or supported housing settings because they are unable to comply with the rules and requirements. The social and physical isolation caused by transitional housing programs separates families from their informal support networks and thereby undermines useful contacts and collaborative strategies of mutual assistance, especially those related to employment and informal housing resources (Novac, 2009). For most High-Needs homeless families, permanent housing with intensive levels of support is necessary to achieve housing stability (Building Changes, 2011).

Homeless Aboriginal people

Population Profile

The literature identifies some key differences between the Aboriginal homeless population and the non-Aboriginal homeless population:

- The experience of homelessness is more multi-generational for Aboriginal people.
- Those who move to the city are younger, more naïve, experience Culture Shock, and find homelessness more stressful than do non-Aboriginal homeless people.
- They tend to have fewer skills and resources to cope.
- Aboriginal homeless people experience a much higher level of discrimination/racism: for example, when searching for employment or housing, racist comments from police and general public, getting “moved along” than non-natives, earning less when panhandling, receiving less help than non-natives at service-providers.
- They tend to have higher levels of addictions, especially heavy drinking and solvent abuse.
- They find fewer services for Aboriginal people than non-Aboriginal people.
- They have a higher incidence of poor health.
- They have historical legacies of residential schools, community displacement, colonization, and the 1960’s Baby Scoop.
- They have stronger ties and obligations to families and relations than non-Aboriginal populations.
- Traditional cultural support is often much more important to Aboriginal people (Ward, 2008; Distasio, 2011; Thurston, 2011).

The Chez Soi Initiative in Winnipeg, which targets the homeless Aboriginal population, found that among the Aboriginal population there is a high level of distrust of “the system” overall, and of the formal health system and health professionals in particular (Distasio, 2011).

Below are recommendations, gleaned from the literature, for provision of housing with supports for homeless Aboriginal people.

- An environment that supports Aboriginal culture and spiritual practice and teachings is central to success: gathering areas for ceremony and community; acceptance of smudging; acknowledgement of the importance of supporting family members; the creation of sacred spaces.
- Spiritual practices were key, not only in Housing First, but also in healing the Aboriginal community.
- Culturally sensitive treatment for addictions, rooted in Aboriginal spiritual practices.
- Immediate access to housing and recovery programs is essential (no waiting period).
- Recreational facilities for youth to keep them off the streets.
- A place where relatives can stay when they visit for the weekend.
- Respect and dignity should be paramount.
- Aboriginal supports for Aboriginal people.
- Harm reduction: promotes autonomy and personal development
(Thurston, 2011; Ward, 2008; Distasio, 2011).

Researchers and service-providers working with the Aboriginal homeless population agree that Housing First is an appropriate approach, as it recognizes that individuals should have access to

housing regardless of any condition, behaviour or social status. There is not agreement, however, on the level of guidance, rooted in prescriptive practice, which may be necessary when working with homeless people, as some may be incapable of making healthy decisions for themselves. Routines and rules were seen as necessary as teaching tools or to protect their health - for those with extremely limited living skills. Housing First's inherent assumption that all individuals can be independently housed was considered by most to be flawed because it fails to recognize that some individuals will never be fully able to live independently, with or without supports (Thurston, 2011).

Immigrants, Refugees and Refugee Claimants

Population Profile

In general, characteristics of homeless immigrants, refugees and refugee claimants differ in a number of ways from the general homeless population. Homeless newcomers tend to:

- Face discrimination in the employment and housing market on the basis of race, immigrant/refugee status, source of income, lack of housing history, and misinterpreted cultural cues;
- Lack family and established social supports to cushion them during crisis events;
- Lack knowledge of income and social supports that can prevent homelessness;
- Rarely have substance abuse/addictions;
- Have limited English language skills;
- Have higher levels of education;
- Lack knowledge of Canadian cultural norms, rules, standards, rights, and laws;
- Rarely use emergency shelters;
- Have much larger families;
- Have protracted histories of persecution and extreme trauma;
- Have had minimal interaction with the law;
- Have a high level of distrust - even fear - of authorities; and,
- Have a higher level of employment than among the general homeless population.

(Hiebert et al., 2009)

Research in a wide range of social science and health fields suggests that although the experience of migration itself does not produce mental illness, the multiple processes of dislocation, movement, and resettlement may together put immigrants and refugees at risk for emotional problems. For refugees and refugee claimants in particular, experiences of war, state endorsed terror and/or political persecution can result not only in physical health problems (due to torture, for example) but also may cause anxiety, stress, depression, and other emotional difficulties. For most newcomers, the process of adjusting to a new economic, social, and cultural climate in the host society can be painful (Access Alliance, 2003).

Refugee claimants, given the combination of their uncertain legal status; lack of eligibility for government supports; lack of connection to their ethno-cultural communities; and, lack of familiarity with Canadian society, are the most likely of all newcomers to “fall between the cracks” of both ethno-cultural community supports and the welfare and housing provisions of the state (Hiebert et al., 2009).

Newcomer women and their families are particularly vulnerable. Among families that came as refugees, many households are woman-led, often due to the male head of the household having been killed or gone missing. In other cases, the difficult process of immigration often causes stresses in relationships that lead to separation of the family. Women who had often never before been involved in the search for housing, employment outside the home, or household finances find themselves the head of their families with all these attendant responsibilities for the first time (Thurston et al., 2006). If unaccustomed to taking a leadership role, advocating for her family, or speaking to authorities, women may not be comfortable with asking for assistance (Thurston et al., 2006).

Housing with supports for homeless immigrants/refugees/refugee claimants would need to offer units large enough to accommodate larger newcomer families. A promising practice that would meet this need is inclusion of flexible housing units that can individually house separate smaller households when needed and also have the capacity to open (via common doors or moveable walls) to connect multiple spaces. Long-term affordable transitional housing with optional supports (up to three years) has proven to work well with newcomers. Supports provided on-site that have proven successful include language learning, cross-cultural learning, child-care, educational up-grading, job-search skills, empowerment, recreation, trauma counseling, computer skills, cooking classes, financial literacy (Best Practice: Immigrant and Refugee Community Organization of Manitoba).

Older Homeless People

Population Profile

For homeless people, the accumulated effects of stress, nutritional problems and untreated health conditions contribute to premature aging and a decreased life expectancy. There is a growing consensus that “elderly” among the homeless population refers to persons aged 50 and over (Serge and Gnaedinger, 2004). Relatively little research has been done with elderly or chronically ill homeless people, likely because they are a small portion of the entire homeless population.

Many of the problems confronted by older homeless persons such as alcoholism, mental illness, poor physical health and addictions are no different from those of homeless people of all ages. Older homeless people, however, are more likely to suffer from dementia, stroke, heart conditions and incontinence. Chronically ill homeless people have more pronounced health issues due to a lack of preventative care or early medical attention. Older people who lack caregivers and are too sick or too weak to return to their previous accommodation are being discharged from hospitals into homelessness. Older homeless people are extremely vulnerable and are frequently victims of violent physical assaults from members of the public (Roebuck, 2008; Serge & Gnaedinger, 2004).

No single housing model has been identified as most effective in supporting the health and well-being of formerly homeless older adults. The literature indicates that a broad menu of housing, health and support options must be available to meet the diversity of needs and preferences of older homeless people (McDonald et al., 2009).

Integrating older homeless people into mainstream facilities probably works best for those who have not been homeless for long or have not been “sleeping rough” or in shelters. Older homeless people who are placed in mainstream residential care may find themselves ostracized for behaviours and habits developed while homeless, such as excessive alcohol use, heavy smoking, poor hygiene, poor housekeeping skills and anti-social behaviour (such as using foul language)(Serge & Gnaedinger, 2004).

Older homeless people often suffer “homeless effects,” the lingering trauma adversely affecting mental health long after being housed. This, combined with accelerated-aging, limits the ability of formerly homeless older adults to recover and to improve health and well-being (McDonald et al., 2009). Although housed, most continue to run up against poverty or welfare walls and find themselves unable to afford such things as meal programs or transportation.

Whether housed in independent scattered site units or in shared residential environments, previously homeless adults between 50 and 65 years of age face formidable and frustrating barriers to improved well-being. Age appropriate services are difficult to find. Efforts to become gainfully employed are constrained by ageism and amplified by histories of episodic unemployment. Homeless effects, such as poor physical or mental health, and ongoing challenges in adapting to “normal” schedules after years of unstable and chaotic living, can make it extremely difficult for these older adults to maintain employment (McDonald et al., 2009).

In 2002-2003, CMHC funded *Housing Options for Elderly or Chronically Ill Shelter Users*, a national study to discover what types of housing options existed for homeless seniors in Canada. Based on examination of 13 housing projects in five different regions of the country, the study developed an ideal supportive housing model for this population:

- A building located away from the downtown core, but walking distance to shops, services and transit;
- 30-50 small, self-contained units, and several common areas,
- Staff available 24 hours a day, seven days a week,
- A holistic approach to client-centred care, and
- Clients would include both men and women.

(Gnaedinger, 2007)

This study also provided the following more specific recommendations:

- Design a beautiful building that is residential in character and that blends in with the neighbourhood. Ensure that it has a garden and trees surrounding it.
- Pay attention to sound transfer in the building and remember that the elevator is used 24 hours a day.
- Ensure that all on-site and visiting staff members share a client-centred, flexible approach to support and that they work cooperatively as a team. Ideally, staff members will be mature adults with considerable life experience.
- Provide one main communal meal per day for tenants, included as part of the monthly rent.
- When selecting tenants for a new supportive housing project, strive for a mix or balance of tenant characteristics, such as physical ability, mental health, sociability, talents and background.
- When seeking tenants for an established housing project, ensure that they will fit into the “community” that already lives in the building (Gnaedinger, 2007).

Homeless People with Mental Health Issues

Homeless people with mental health issues do not respond well to change as it can create or add to anxiety, stress and a sense of instability. Therefore, for this population, transitional housing is not recommended. Requiring residents with mental health issues to change their housing as they improve or regress in functioning is viewed as not “normalizing” and possibly harmful. Having to give up familiar living arrangements and in some cases important relationships they have developed, simply because of improvements in functioning and advances in recovery is viewed as a disincentive to progress toward these goals. Moving persons out of autonomous settings and into more supervised settings when problems arise is also seen as unnecessarily adding to stress and perhaps jeopardizing gains made in addressing mental illness. A 1990 study surveyed homeless mentally ill consumers and found that they preferred permanent housing and more flexible supports than can be provided by programs based on the continuum model (Brown, 2004).

Without a range of housing and related support options, people living with mental illness are vulnerable to being stuck in arrangements that are mismatched to their needs. One place where this occurs is with people in hospital (often referred to as alternate level of care, or ALC patients) who have nowhere suitable to be discharged. ALC patients are in hospital when they could be living in the community, a dilemma arising from a lack of appropriate housing and support options. The costs of this are high – someone who does not need the level of support a hospital provides occupies an expensive bed. Results from an Ontario- based study indicate that more than 50% of ALC patients are in psychiatric settings, consuming a significant portion of inpatient resources. Additionally, 60% of mental health ALC patients in acute care hospitals stay for more than 90 days in a single hospitalization. This number rises to 65% in tertiary or specialized hospital settings. Alternate level of care (ALC) is used to describe patients who no longer require hospitalization but remain in hospital until discharge to a more appropriate level of service (Mental Health Commission of Canada, 2010).

Homeless people with Active Addictions:

Transitional housing is considered more appropriate for some groups than others. In one study, people in recovery from substance abuse were the most frequently named by service providers as needing the transitional environment (Novac et al., 2009). Those lacking a circle of friends and family, who would support their abstinence-based recovery, generally do less well than those who have informal social supports. The community reinforcement approach that is part of the transitional housing experience has consistently been shown to be effective with clients in recovery who have fewer social supports and more severe drinking problems (Dinning, 2008).

One research study sought to identify which housing interventions and factors that incorporate a harm reduction approach best help the homeless population with active addictions access and maintain stable housing. The findings indicated that the best results were achieved by those agencies that worked to actively engage their clients in making positive changes in their lives. Some of the approaches used include motivational interviewing (to help clients enhance their motivation to address their substance use issues), focusing on the strengths and capacities of each individual— rather than on their limitations, and providing the necessary support and information to help clients reduce their substance use or to use more safely. As stated by one agency, the approach is one of “persistence” rather than “insistence”.

Essentially, it was housing that was key, as it provided the safety and security that made it possible for people to begin to reduce their substance use. Housing also provided a base for the residents to form friendships, get to know and respect themselves, develop and establish their own networks, and become connected to the community (Kraus et al., 2005).

Agency key informants also identified the following as reasons for success:

- A harm reduction approach that provides the context for flexibility and a “client-centred” approach in working with program participants/residents;
 - Flexible and intensive case management—based on a trusting and respectful relationship, including a relationship that helps provide hope, optimism and real opportunities for moving beyond homelessness;
 - A high level of support—including support staff being available in the evenings and on weekends;
 - The role of staff—their approach, attitude of helpfulness and way in which they treat participants with respect;
 - Collaboration among agencies—particularly between the housing and service providers;
 - Connections with community services—to help participants get involved in community activities and be able to contribute to the community;
 - Social activities for the program participants/residents— including communal meals; and,
 - Stable funding.
- (Kraus et al., 2005)

In the same study, when discussing what was important to them in terms of their housing, participants indicated that they want affordable housing in quiet neighbourhoods away from drug dealing, but accessible to public transportation, amenities and services. It is clear that a range of housing options is necessary to meet the needs of the target group. While some individuals prefer the anonymity and strictly “landlord-tenant” relationship that occurs with scattered site housing, others prefer the camaraderie, group activities and sense of community that is available in dedicated buildings. This brings up the question about whether the distinction between “permanent” and “transitional” housing continues to be useful, especially if there are no reasons for housing programs to impose time limits regarding a resident’s length of stay (Kraus et al., 2005).

According to reviews of comparative trials and case series reports, Housing First reports document excellent housing retention, despite the limited amount of data pertaining to homeless clients with active and severe addiction. Several linear programs cite reductions in addiction severity, but have shortcomings in long-term housing success and retention. The current research data, specific to homeless people with active addictions, are not sufficient to identify an optimal housing and rehabilitation approach for this homeless sub-population. Therefore, policymakers should be cautious about generalizing the results of available Housing First studies to persons with active addictions (Kertesz et al., 2009).

Homeless people with Complex Issues

Population Profile

The portion of the homeless population with complex issues may also be referred to as having multiple diagnoses, multiple disorders, intensive needs or complex support needs. This is not

the same as, but does include those with dual diagnoses and concurrent disorders. Sometimes this sub-population is labeled as “service-resistant” due to numerous failed attempts to address some or all of the issues they face. Another common term is “Hard-to-House” in reference to multiple failed attempts to maintain stable housing. This sub-population shares the characteristics common to the general homeless population. A homeless person with complex issues not only has more issues, but each is more intense, entrenched and protracted, and the interactions between their issues further intensify the magnitude of the effects. The people in this population tend to be older, have been sleeping rough or in shelters, and have been homeless for very long periods of time, often for a decade or more, intermittently or continuously.

Unlike the general homeless population, those with complex issues will often pose a significant risk of harm to themselves or others and display anti-social or challenging behaviours. They are heavy users of emergency services. The intensity and interaction of the challenges they face causes their functional abilities to be severely limited, which makes them highly vulnerable to abuse and exploitation on the streets (KPMG and OrgCode; 2011 Barrow, 2004).

This high-risk homeless sub-group suffers severe harm as a result of high rates of drug use, consumption of alcohol-based substances (mouthwash, solvents for example) containing harmful substances, assaults, and robberies. A broader type of harm results from neglect and estrangement from social networks, family connections and human contact. As a result, these individuals are at higher risk for health (both physical and mental) problems that further exacerbate their homelessness (Tremblay, 2009).

Their experiences of extreme physical and mental harm are manifest in behavioural patterns, common among homeless people with complex issues. The consequences of traumatic brain injury, for example, may include cognitive impairment, attention deficits, disinhibition, impulsivity and emotional instability (Hwang et al., 2009). Another behavioural pattern, common among homeless people with complex issues, is a highly fluid and inaccurate notion of time. They are frequently unaware of timelines, how long they have resided somewhere, and in some cases even present time and date. This distortion of time has a significant impact on a variety of social skills. To an outsider, time distortion may appear as indifference, lack of motivation, or even a signal of more serious mental illness.

Time distortion has not been formally described extensively in the literature on homelessness, but clearly it represents a unique and important type of personal vulnerability. Understanding the experience of time distortion and how it affects homeless people should assist those working to meet the needs of this population (Tremblay, 2009).

Homeless people with complex issues face a number of barriers to accessing needed services:

- The “behaviours” and issues faced by this population quickly earn them reputations that result in them being banned from existing community programs and services that could help.
- The intensity and/or complexity of their needs may be too extreme for the expertise or capacity of individual service providers.
- Individuals discharged from the justice system must reapply for government supports such as Assured Income for the Severely Handicapped (AISH) after they are released.

- Access to community-based health and mental health services appears to be a particular challenge for these homeless individuals due to barriers such as lack of transportation, inability to keep appointments, and inability to navigate the system.
(KPMG and OrgCode, 2011)

Homeless people with complex issues face multiple obstacles to housing stability, and are likely to require a range of services that are often dispersed across different service systems (Gerber et al., 2008). Housing is key to recovery. More so even than supports, the availability of housing for previously homeless individuals with complex issues is linked clearly with positive outcomes in recovery life domains (Dinning, 2008).

Housing with Supports for Homeless People with Complex Issues

Looking to the literature for the definitive identification of models of housing with supports that work best for homeless people with complex issues is problematic. The international evidence base regarding housing interventions for this group is, in fact, very limited. In the United States, for example, the development and implementation of innovative programs for homeless people with complex support needs have outpaced the conduct of rigorously designed research focused on this population, such that “while available research suggests promising approaches and implications for practice, it sometimes falls short of meeting the highest standards for defining evidence-based practice” (Johnsen and Teixeira, 2010). In addition, no empirical study has been able to distinguish the features of housing that are the active ingredients of housing that make the difference in residential outcomes for this sub-population. Moreover, most studies have not adhered to a strict definition of supported housing or supportive housing and have not specifically examined each principle (Patterson et al., 2008).

The range of physical configurations of supported housing alone makes project-to-project comparisons difficult. Physical configurations include scattered site arrangements where clients occupy a single apartment within a standard apartment complex, clustered scattered site arrangements with a small apartment building set aside for program tenants on a block with no other such buildings, and larger mixed-use buildings where a small portion of units are leased by a housing provider with the understanding that a specific number of units will go to homeless clients. What can be said is that there is little evidence to suggest that certain housing configurations are linked to better outcomes for homeless people with complex issues (Gerber et al; 2008).

All well-designed empirical studies looking at housing for homeless people with complex issues have noted a positive impact of supported housing on residential outcomes over time. Once in housing with supports, the majority of individuals with substance abuse and mental illness (SAMI) stay housed, are less likely to become homeless, and are less likely to be hospitalized, regardless of the specific type of housing condition (Patterson et al., 2008).

Predictors of Housing Stability

In terms of being able to predict which homeless people with which combination of issues will be most likely to retain housing, the literature is contradictory.

- A significant body of research demonstrates that substance abuse is a predictor for shorter tenure or tenancy failure in supported housing programs. One US stakeholder interviewee acknowledged that the vast majority of tenancy breakdowns amongst his organization's Housing First clientele were of people involved in drug misuse (Johnsen & Teixeira, 2010).
- One agency that uses a "Housing First" approach indicated that, though not predictors of success or failure, two factors that are statistically associated with those who lost housing in this housing model are substance abuse and non-compliance with medications. Their evaluation goes on to state that success or failure of tenancy cannot be predicted by severity of illness or by any other single factor or aggregation of factors (even substance abuse or non-compliance with medications) (Dinning, 2008).
- Whether the accommodation itself is shared or private appears to be of greatest importance in predicting the pathway to or from homelessness (Anucha, 2003).
- Additional correlational studies have found that achieving housing stability is related to choice and to matching individual needs and preferences with appropriate settings (Goering et al., 1997).
- A broad review of studies found that housing stability was related only to access to rental subsidies (Patterson et al., 2008).

Problem of Measuring Program Success Only by Housing Stability

Any indicator or group of indicators of housing stability alone is insufficient to determine housing with supports program success or failure for homeless people with complex issues. Because it has been found that providing supported housing to homeless people with complex issues provides the context for them to then address other issues, housing stability has become a proxy for measurement of overall program success. Housing stability is a means to an end, but should not be considered to represent the ultimate end goal.

Reviews of outcomes of Housing First programs reveals that "other core elements of psychiatric recovery such as hope for the future, having a job, enjoying the company and support of others, and being involved in society ... have only been partially attained". Similarly, a 2007 study of Pathways clients in the United States concluded that although the clients interviewed had been stably housed for an average of three years, they seemed to live "lives without any involving pursuits or set of meaningful social connections" (Johnsen & Teixeira, 2010).

Data on the financial wellbeing of Housing First customers is especially sparse. The few studies mentioning such outcomes suggest that the model is effective in ensuring clients receive all the welfare benefits to which they are entitled, but that many continue to live in poverty (Johnsen & Teixeira, 2010). For example, in a 2007 study of 88 Streets to Homes' (S2H) Housing First clients in Toronto, 68 per cent reported that they did not have enough money to live on after paying rent (City of Toronto, 2007). Roughly two-thirds of respondents reported that they "regularly ran out of money to buy food" and of all the services they have used once housed, food banks are by far the ones that they use the most. Fewer than 10 percent of S2H participants had a telephone. Only 40 percent of respondents to the post-occupancy survey reported that their social interaction had improved since being housed. In fact, 26 percent of respondents reported that their social interaction had "gotten worse" (City of Toronto, 2007).

Linear Continuum

Some commentators have concluded on the basis of the evidence available that the linear approach can work particularly well with people who are willing to engage with rehabilitation programs and are able to cope with shared housing arrangements. However, a number of academics have recently argued that the evidence base regarding the efficacy of transitional supported housing for homeless people with complex support needs and other vulnerable groups is actually very weak (Caton et al., 2007; Chilvers et al., 2009).

Many homeless people with complex needs are unable to meet the demands of such a system and therefore fail to progress to the 'end' of the continuum or reach the top 'step', that is, achieve independent living (Kertesz et al., 2006). This means that the staircase system has lost credibility in the eyes of some homeless people, as they are reluctant to persist in pursuing housing after having been humiliated by the rules, surveillance or harsh sanctions of projects, or because they feel let down despite good conduct and patience (Johnsen & Teixeira, 2010). Many researchers postulate that the housing transitions inherent in the continuum model may disrupt clients' social relationships and sense of stability. It is also claimed that successive moves may jeopardize gains in daily living skills made in previous programs (Patterson et al., 2008). In addition, homeless subpopulations are not equally likely to enter the housing and service arrangements associated with the greatest likelihood of housing stability. Substance abusing and/or mentally ill people may be reluctant to enter housing arrangements that require sobriety or participation in treatment programs (Gerber et al., 2008).

Scatter-Site Mainstream Self-Contained Housing

A wealth of evidence confirms that the vast majority of homeless people express a preference for mainstream self-contained housing and that those offered the greatest housing choice are more likely to report greater satisfaction with their housing and neighbourhood (City of Toronto, 2007; Johnsen & Teixeira, 2010; Patterson et al., 2008). Goering et al. (1992) found that homeless people with substance abuse and mental illness (SAMI) preferred permanent housing and more flexible supports than could be provided by programs based on the continuum model. Similarly, female users of hostels and drop-in centers expressed a preference for permanent, independent housing with a higher level of privacy than is the case in many continuum programs (Patterson et al., 2008).

Client preference studies have focused on the principles of types of housing with supports, and indicate that individuals consistently voice their preferences to live in housing that has flexible supports, is their own, and is affordable, permanent, and integrated into the community (Patterson et al., 2008). Scatter-site units are reported to foster client recovery by building their sense of responsibility and stability, but are sometimes associated with social isolation, and are costly in terms of the time and resources required for travel to meet clients. A number of commentators argue that for some homeless people with complex support needs, fully independent housing may be neither a realistic, nor desirable, goal (Johnsen & Teixeira, 2010).

Permanent Housing with Supports

Complex issue homeless populations typically require housing linked with support services, and some research suggests that voluntary services are more effective than mandated treatment or

sobriety. In addition, housing and services provided in the context of emergency or transitional shelter do not often lead to successful housing outcomes for this population. Homeless people with mental illness or substance abuse are best served by permanent supportive or supported housing (Gerber et al., 2008).

Success of the Support Piece of Housing with Supports

A review of the literature indicates that impacts of housing on outcomes other than those related to residential stability and hospitalization have not been consistently studied, and the studies that have been conducted do not yield consistent results. For example, while some studies have shown that increased residential stability is correlated with improved illness management and treatment outcomes, the evidence for improvements in psychiatric functioning as a result of supported housing are mixed and inconclusive (Patterson et al., 2008). In San Diego, Hurlburt et al. found differences for access versus no access to rental subsidies, but did not find differences between housing that had intensive vs. traditional case management (Patterson et al., 2008). Many researchers and providers argue that treatment strategies have little or no effect and are often declined by clients unless they feel safe and satisfied with their housing (Hadley & Culhane, 1993; Patterson et al., 2008; Brown, 2004).

Very few studies have examined associations between clients' demographic characteristics and Housing First effectiveness. (Johnsen and Teixeira; 2010) The Housing First literature to date suggests that this model is successful with several homeless sub-populations; however, women as a sub-population have been largely ignored. Schiff & Waegemakers-Schiff (2010) argue that due to the limited research on this model with other populations, "it is thus premature to conclude that this is an appropriate model for all other housing insecure groups" (p. 71) and further highlights the absence of research examining culturally appropriate services for Aboriginal women. Kertesz et al. (2009) share similar concerns, noting that the effectiveness of the Housing First model has not been demonstrated for those struggling with combined addiction and criminal justice issues as well. In contrast to Housing First models, transitional housing, or studies examining the effect of the continuum of care model is strongly lacking. What results then, according to Kertesz et al. (2009), is that neither approach has been demonstrated consistently to be effective for all populations (Fotheringham et al., 2011).

Homeless People with Pets

The relationship between humans and their pets has been well documented. About half of Canadians own a cat or dog and Americans, on average, have more dogs than children (Labrecque & Walsh, 2011). Homeless people also own pets. Many have cats and rats, with dogs being the most popular choice (Taylor, Williams, & Gray, 2004). There is very little research about homeless people's relationships with their pets. In fact, according to Labrecque & Walsh (2011), there have only been five published studies with none of them exploring this issue within a Canadian context. The few studies that exist illustrate the close bond that develops between homeless people and their pets. "Those without a home, the aged, those with a mental illness, those sleeping rough, victims of domestic violence or natural disasters, often have a higher degree of attachment to their pets (Labrecque & Walsh, 2008) than the securely housed and severing this bond can be traumatic to both owner and pet."

In addition to these close bonds, there are other benefits which dog ownership affords:

Companionship

The presence of pets has been found to have a positive influence on the health and emotional well-being of their owners and compensate for the lack of human companionship. They reduce social isolation and feelings of loneliness, nonjudgmental companionship and increased human social interaction. When asking homeless youth how they cope with loneliness, Rew (2000) found that the majority of subjects coped with their loneliness in one of two ways: being with friends or having a dog. Many youth indicated that they always had their dog by their side, always there to talk to. "They climb in your sleeping bag with you and keep you company. They just know. They know when you're alone. They know you need a lick across the face" (Rew, 2000).

Acceptance

Having a dog provided unconditional love, which is something many homeless people have rarely experienced in their lives (Rew, 2000). Ptak (1995) quoted respondents as saying: "He's the only thing that loves me." "She doesn't mind that I'm dirty or smell – she loves me anyway."

Comfort

Social isolation can be a common experience for the homeless. To help them through hard times, pets have been shown to provide great comfort, providing owners with much needed emotional support (Labrecque & Walsh, 2011).

Responsibility

Labrecque & Walsh (2011) illustrated that homeless dog-owners feel motivated and a sense of accountability to their pets. The needs of their pets are always placed before their own. They feed their pets first and the medical needs of their pets will come first. Rew (2000) contends that this sense of responsibility also motivates the homeless, particularly youth, to make appropriate choices, as opposed to the high-risk choices from the past, as this ensures that they will always be around to take care of their pet: "So you have to make different choices about what you do with your time and how you spend your money" (Rew, 2000).

Health Benefits

The research highlights the health benefits of owning a pet for homeless people. A pet will motivate its owner to stay healthier, as evidenced in Rew (2000): "Having a dog makes me feel like I gotta stay healthier so the dog's okay. I mean, if I just sit there and kick off somewhere the dog's going to be stuck by herself." Half the respondents who Labrecque & Walsh (2008) interviewed indicated that pets benefit them psychologically; with comments "You feel more relaxed" and "become more calm". Taylor et al. (2004) have also shown that pet ownership has been shown to decrease drug dependency through fear of imprisonment, which would separate the homeless from their loved companion.

Safety

A number of homeless people, particularly women and youth, will own a dog to protect them against violence from perpetrators, and to guard them while sleeping rough on the street (Flynn, 2000; Labrecque & Walsh, 2011).

Challenges to Pet Ownership

There are numerous challenges associated with pet ownership for people who are homeless:

1. Expense of owning a pet

Pet food and health care can be quite costly, yet the research confirms that homeless people will always put the needs of the pet before theirs, often at the expense of their own health. Many homeless youth have become resourceful in providing for the care of their pets; for example, some have assisted veterinarians (sleeping in the parking lot at night, as vet offices have numerous break-ins) in exchange for free service (Irvine et al., 2012).

2. Pet restrictions of shelters, programs and services

Shelters and homeless-serving programs and services will often not allow pets in their facilities.

3. “No pets Allowed” Housing

The majority of housing options have strict “no pet” rules. Only 2 percent of social housing in Calgary allows cats or dogs (City of Calgary, 2012). Homeless people with a sincere desire to be housed, will refuse housing if they are unable to take their pet with them, or if the accommodation does not meet the needs of their pet (Singer et al., 1995). As the majority of hostels, cold-weather shelters, congregate housing and private market rental apartments do not accept dogs, many homeless people remain on the street for years (Taylor et al., 2004). Findings from Cronley et al. (2009) has shown that “61% of acutely and 93% of chronically homeless individuals with animals wished to find housing, but 96% of acutely homeless and 93% of the chronically homeless individuals said they would never live without their animals”.

3. Public confrontation

Homeless people with pets often experience public confrontation. Much of the public expresses that if homeless people are unable to take care of themselves, they should not have the right or ability to own a pet. Many try to purchase the pets outright from the homeless (Irvine et al., 2012).

Conclusion

When homeless youth admit to their feeling of loneliness, they become very intentional about finding ways to overcome these feelings. Rew (2000) found that caring for a dog shows that some youth cope with homelessness in ways that enable them not merely to survive, but to develop in healthy ways that may mitigate the circumstances that otherwise make them vulnerable to unhealthy development and emotional distress.

Studies have shown the extreme attachment that homeless people have with their pets, as these companions are viewed as their only source of love and companionship (Cronley et al., 2009). Based on the findings of the numerous benefits associated with owning a pet, Labrecque & Walsh (2008) recommend that homeless-serving agencies explore ways in which pets may be incorporated into their programming.

HOUSING POLICIES AND LEGISLATION

Housing Policy in Canada

Gaetz (2008) defines housing policy as “the actions of government, including legislation and program delivery, which have a direct or indirect impact on housing supply and availability, housing standards and urban planning.”

Housing policy in Canada is shared amongst federal, provincial and municipal governments and is inclusive of the respective roles of industry and nongovernmental organizations and other stakeholders. The availability of safe, affordable housing is a major factor in ensuring that people who live in extreme poverty are able to find and maintain shelter. This availability, dependent on housing policies has a direct impact on homelessness (Gaetz, 2008).

In addition, legislation involving tax and housing policies and resource allocation has a direct impact on housing prices, affordability, and the availability of rental housing. Housing and tax policies also affect social housing investment by providing incentives for private sector developers to build more rental and affordable housing for low and moderate income households (Gaetz, 2008; CHRA, 2009).

Social housing in Canada has experienced substantial changes over the past two decades. In the 1990s social housing “devolved” completely from federal to provincial governments and Canada remains the only major country without a national housing strategy. As a result of this “devolution”, the provinces have authority to allocate funding to regulate and administer social housing policies. With the exception of Ontario, provinces have continued to set their respective social housing programs using a “centralized model” (Schuk, 2009).

Canada’s housing system provides for several forms of housing including homeownership, private rental housing and social housing thus making available a wide range of housing options for a diverse population. In recent years however, housing costs in Canada have increased while the income that low and moderate income households have to spend on housing has not. In addition, a large amount of Canada’s rental housing stock is old and in need of repair and much of it is being torn down for urban renewal or upgraded and converted to condominiums. With their limited income, many people are forced to live in unaffordable or inadequate housing, often resulting in homelessness (CHRA, 2009).

Canada’s lack of a strong, comprehensive national housing strategy is further compounded by recent changes in related social programs such as income support, resulting in the social housing area of Canada’s housing system becoming “overburdened” and households with moderate incomes in many communities finding it difficult to purchase a home (CHRA, 2009).

Hulchanski, (2007) states housing policy decisions since the mid-1980s have contributed to a growing gap between the have and have-not households in Canada. This has become increasingly evident in the current housing system that is divided into two “separate and distinct housing subsystems” that are unequally supported by government. This “dual housing policy” consists of a “primary part” consisting mostly of homeowners and renters at the upper end of

the rental housing market, and a “secondary part” which includes low-income families and individuals and residents of poor-quality, subsidized housing.

This “dualism” is evident in the unequal distribution of benefits and supports and continues to be a “key factor” in the design of housing policies and programs in Canada. Hulchanski (2007) argues that the primary section of the housing system receives universal benefits and entitlements including government-managed mortgage lending and insurance programs, tax relief on capital gains for home owners, programs to assist with down payments and greater amenities and community services in districts with higher home ownership and upper end rental housing. Low-income households, on the other hand, receive benefits of a “selective, means-tested basis” that often meet minimum needs.

However, some progress has been made. Recent policy initiatives such as the federal, provincial and territorial Affordable Housing Initiative, that stimulates affordable housing development with capital grants, has helped create over 20,000 units of non-market housing since 2001. In addition, the federal Homelessness Partnering Strategy (HPS) was deemed an international best practice by the UN Habitat for providing homeless assistance services such as transitional and supportive housing to address homelessness (CHRA, 2009).

Additional policy measures such as the Registered Home Ownership Savings Plan and strategies to exempt principal residences from capital gains tax have been implemented to promote homeownership support areas of the housing system but have been noted for not addressing the “affordability problems” of households with very low incomes (CHRA, 2009).

The Need for a National Affordable Housing Policy

A comprehensive affordable housing policy for Canada is a responsibility shared between all levels of government and local communities. Policies and legislation should build and expand on the existing federal housing and homelessness initiatives, ensure housing system components such as home ownership, rental housing, social housing and emergency shelter are functioning to provide all citizens with a decent and secure place to live. They should also invest in the housing system to provide a range of appropriate housing solutions for diverse populations, including low income Canadians and people with special needs (CHRA, 2009).

Principles of a National Housing Policy

The Canadian Housing and Renewal Association (2009) states that a national housing policy must first regard adequate housing as a “basic necessity of life”. It is a “fundamental human right” and a “key determinant of health”. Such a policy must ensure that access to adequate housing for all Canadians becomes a national priority (CHRA, 2009). By ratifying the International Covenant on Economic Social and Cultural Rights (CECSR) in 1976, Canada guaranteed the right to a standard of living that includes adequate housing (Pearce, 2010)

The CHRA suggest that a national housing policy should include the following elements:

- Commitment from all levels of government
- Provision of long-term financial investments and support from federal and provincial governments based on the identified needs of local communities

- Flexible government investments that are responsive to community needs, including aboriginal communities, and are respectful of the way housing is delivered throughout each of the provinces and territories
- The involvement of local decision-makers to identify housing types and determine the social supports to meet the needs of the community
- Evidence-based and outcome-focused solutions and systems to monitor and evaluate outcomes

(CHRA, 2009)

Government Policy and Mechanisms

An effective, functioning national housing system must be informed by a broad range of policies and mechanisms provided by all levels of government. Broadly including legislation, regulation and financial investment, specific policies and mechanisms may include:

- Income systems to maintain and enhance resources available to households to meet housing costs
- Eviction prevention measures
- Investment in maintenance to ensure the sustainability of existing affordable and social housing
- Measures to enhance affordable housing development including increasing density, changes to bylaws and zoning, and accelerating the approval processes
- Introduction of tax measures to maintain existing housing and promote new housing development
- Elimination or reduction of fees and levies on residential construction
- Provision of capital grants and/or operating subsidies to stimulate investment in the development of new housing
- Subsidies for existing housing or provision of allowances to low income individuals to increase housing affordability
- Integration of housing with other related social, economic and employment initiatives

(CHRA, 2009; Eggleton, 2008).

Policies to Promote Affordable Housing

Federal, provincial and municipal governments can affect housing affordability through policies, regulations and legal and planning frameworks. These strategies could include:

1. Modifying Building Codes

Modifying building code requirements can help make affordable housing more viable by lowering renovation or construction costs, thus helping the private market respond to the needs of low-income people. Examples could include:

- a) Modifying policies regarding minimum house and apartment size to reduce required floor area of single room occupancy units provides a proportionate reduction in construction costs and gives more low income people access to market housing, and
- b) The cost of upgrading a single room occupancy building according to modified municipal guidelines developed by The City of Edmonton was \$2,381 per unit, compared to \$13,522 per unit to upgrade comparable units to the standard of the Alberta Building Code (CMHC, 2012).

2. Modifying Development Standards

Changes to planning and engineering standards guiding design and construction of residential communities is an effective way of reducing land and servicing costs resulting in increases in housing supply and lower housing prices. For example, lots can be smaller or configured differently to increase densities and parking spaces can be reduced in affordable rental projects for low-income people thereby reducing the cost of development (CMHC, 2012).

3. Permitting Secondary Suites

Secondary suites have been recognized by policy makers as one of the most cost-effective ways of providing affordable rental housing. The rental income generated from secondary suites also makes housing affordable in high cost areas allowing for older homeowners to continue to live in their neighborhoods. Secondary suites make up close to a fifth of the rental stock in Toronto and Vancouver. They are also an important source of rental housing in smaller towns and in rural areas where there is little conventional rental housing. Secondary suites can reduce carrying costs to first time homebuyers by up to 25% (CMHC, 2012).

4. Providing Garden or Garage Suites

Garden suites, small self-contained dwellings placed on residential properties, have been introduced in a number of municipalities across Canada. They are often used for low-income tenants and as in-law suites that enable older adults to live independently and affordably in the community while receiving informal support from family members. Policy approaches used to regulate garden suites include temporary use by-laws, zoning by-laws, site control and licensing (CMHC, 2012).

5. Reducing Length of Approvals

Effective policies to decrease the length of the approval process reduce the costs of residential development and lower housing costs. Municipalities can decrease the length of approvals by offering standardized application forms, extended business hours, pre-consultation services as well as fast-tracking the development approval process for affordable/low income housing development. In addition, policies to address and reduce NIMBY (Not in My Back Yard) attitudes can also help avoid prolonging the approval process. The City of Kamloops fast tracks affordable housing projects and has recently reduced the development approval process from 12 to 14 weeks to six weeks (CMHC, 2012).

6. Retaining Affordable Housing

Policies and regulations to encourage or require building owners and developers to retain existing affordable housing stock is a key affordable housing strategy in communities where low-income housing is decreased as a result of redevelopment, condominium conversions or renovations to high-end rental units. Municipal by-laws may further preserve housing by limiting conversions or demolitions of affordable rental housing; require replacement units at similar rents and transferring development rights from affordable rental housing to other sites. Toronto, Vancouver and Montreal have policies and by-laws that promote the retention of existing affordable rental housing (CMHC, 2012).

7. Using Development Levies

Development levies can stimulate or fund the development of affordable and low-income housing by requiring developers to pay a fee to support affordable housing as a condition of approval. Fees may also be waived as incentive for developments that include affordable units as part of the housing mix. Ottawa has removed development charges in the central part of the city to encourage investment in residential developments in the downtown area and some municipalities in New Jersey apply development levies to residential uses to secure funds for affordable housing (CMHC, 2012).

8. Using Inclusionary Housing Policies

Inclusionary housing policies require the provision of affordable housing as part of residential developments and have been initiated at a provincial/state or municipal level in the U.S. and Canada including New Jersey, Ontario and Burnaby, British Columbia. Most inclusionary housing policies apply to new developments and can be either mandatory or incentive-based. Mandatory policies require developers to include affordable housing units as a condition of development approval with density bonuses and other concessions provided to offset developer costs. Incentive-based programs encourage builders to contribute voluntarily to affordable housing in exchange for density bonuses and other offsetting incentives such as fast tracking of approvals and reduced development standards. The minimum proportion of affordable housing varies according to the municipality or region and range from 10 to 25 percent of the development (CMHC, 2012).

SmartGrowth BC, in a 2007 report on Affordable Housing (Wake, 2007) depicted the variety of affordable housing in this way:

Affordable Housing						
Emergency Shelters	Transitional Housing	Social Housing	Affordable Rental Housing	Affordable Home Ownership	Affordable Rental Housing	Affordable Home Ownership
Government Subsidized Housing (social housing)			Non-Market Housing		Market Housing	

This report identified best practices that “truly resulted in the production of affordable units” (Wake, 2007). A partial list follows:

- Inclusionary Zoning; regulations that require affordable housing development as a percentage of developed units
- Density Bonus; allowing increases in density tied to delivery of some beneficial amenities
- Rent Restrictions; more common in U.S.
- Resale Price Restrictions
- Secondary Suite Allowances; while these exist everywhere they are often not recognized or encouraged
- Dedicated Housing Funds
- Public/Private Partnerships
- Dedicated Housing Organization

Current Canadian Housing Policies on Housing Subsidies

For years, the federal government played a leadership role in housing policies and was involved in the planning and delivery of programs, direct federal grants and loans. In 1986, the federal government began to transfer the operation and authority for housing programs to the provinces and territories (Carroll et al., 2000). In the last decade, federal housing programs consisted of short-term initiatives with duration of no longer than three years (Eggleton, 2008).

Recently, long-term federal funding for hundreds of thousands of non-profit, co-op, and public housing units in Canada began to run out as operating subsidies expired with the mortgage of these properties. As this trend continues, it is estimated the federal government will eventually cease to completely fund these types of housing units in the next 20 years. This will impact all social housing built prior to 1994 and represents approximately \$1.7 billion in annual funding (Policy Fix, 2012; Eggleton, 2008).

The withdrawal of federal funding is estimated to have “dramatic consequences” on Canada’s housing system particularly as tenants living in non-profit housing, who pay rent geared to their income, lose their CMHC funding. As many social and affordable housing organizations rely on these operating grants to allow them to offer units at rents lower than market rates (often as much as \$200/month lower), continuing the practice may be challenging and low-income tenants could experience unreasonable rent increases and possible displacement (Policy Fix, 2012; Eggleton, 2009).

Today’s housing policies reflect the demographics and economic conditions that include a widening social gap, an aging population and smaller, non-traditional family units. Current policies under provincial leadership feature municipal and community involvement and private sector partnerships resulting from financial pressures. Most provinces have introduced programs that reflect their own demographic and housing needs. In a climate of fiscal restraint, these programs would focus on mixed accommodation in the housing market and emphasize building repairs and rehabilitation due to older housing stock (Carroll et al., 2000).

Other economic and demographic factors that current provincial housing policies must take into consideration are low vacancy rates due to new Canadians, rural to urban migration, younger renters, lack of affordable housing and rental units lost to condo conversion since 1992. In addition, average rents continue to rise due to higher land prices and greater construction, maintenance and operating costs (Mulligan, 2008). This has led to an increase in federal housing policy and programs encouraging public-private partnerships including those with the Canada Mortgage and Housing Corporation (CMHC) with a view to applying them to the creation of social housing (Eggleton, 2008).

Policies and Approaches for Addressing Housing in Canada

Canadian housing policies are utilized to either increase the number of housing units in the market (supply side) or address barriers individuals and families face when trying to obtain suitable housing (demand side). In the past, supply side initiatives often took the form of large-scale government construction to create affordable housing units, typically in the form of rent-geared-to-income units. As a result of isolation, stigmatization and negative reaction from surrounding communities, large-scale housing “projects” have largely fallen out of favor. Policy makers are instead looking to integrate those facing housing challenges into established communities to take advantage of the inherent strengths and assets that already exist within

the community and reduce exclusion and the stigma associated with poverty (Government of Canada, 2005).

The Government of Canada (2005) suggests housing policies should not be created in isolation, but rather in concert with other related social and economic policies that target low-income households and long-term poverty. The relationship between housing policies and the “broader social policy agenda” is becoming increasingly more apparent. For example, housing stress can “potentially undermine” social and employment programs and services for people in need. Conversely, incorporating and aligning social supports with housing policy can make housing programs and services more effective in addressing and reducing housing stress.

Financial Assistance Policies for Housing

On November 30, 2001, the federal, provincial and territorial ministers responsible for housing agreed on a framework that would increase the supply of affordable housing across Canada. With this agreement, the Government of Canada negotiated individual agreements with every province and territory to fund the creation of affordable housing throughout the country through either new construction or rehabilitation with a \$1 billion federal investment in the Affordable Housing Program (Government of Canada, 2005).

Financial assistance policies include the use of housing subsidies to assist low-income people to access and maintain adequate, affordable housing. Alberta, British Columbia, Manitoba, and Quebec use direct housing allowances for people who meet certain criteria. Housing subsidies may be paid to eligible tenants or directly to landlords of qualified, rental housing. Housing subsidies or rent supplements are based on a percentage of gross household income, generally established at no more than 30 per cent (Government of Canada, 2005).

The effectiveness of housing allowance policy and programs often depends on market conditions. In communities with high vacancy rates landlords are more responsive and accept the income security that subsidies provide to their tenants. However, when vacancy rates are low landlords can afford to be more selective in screening prospective tenants. In addition, tight housing markets and rising rents result in the need for subsidy levels to follow suit in order to remain viable and relevant. This can “undermine the cost effectiveness” of housing allowances particularly since subsidies use resources that do not result in direct changes to the housing market, such as new rental unit construction. Thus, housing subsidies and allowances appear to be more effective in housing markets with high vacancy rates and a good supply of affordable housing (Government of Canada, 2005; Eggleton, 2008).

Alternative Forms of Housing

Flexible, innovative reforms in areas such as income support, construction financing, zoning by-laws and intergovernmental coordination could significantly impact affordable housing by lowering costs and increasing production. Habitat for Humanity, a non-profit housing organization, has identified a number of alternative dwelling strategies that can reduce the cost and increase the supply of affordable housing. These include:

- The Grow Home concept where homes are built with “basic living quarters”. Provisions for finishing the remainder of the dwelling will be added on to as needs and income permit.

- The “Quattroplex design”, a four separate housing unit, contained within a large, single detached home with shared foundations, walls, roof, and land, lowers costs and increases affordability. This design has been used successfully in a housing subdivision in Brampton, Ontario.
- Prefabricated homes can be built and installed at a cost of up to 35 percent less than conventional homes.

The widespread use of these “alternative dwelling forms” has been restricted by non-variable building codes and zoning policies. Innovative partnerships between governments, the private sector and the voluntary sector are required to realize the “economies of scale” required to use these new housing forms to the best advantage (Government of Canada, 2005).

Legislative Housing Policies for Low-Income Renters

Low vacancy rates and high rental costs put pressure on a number of Canadian rental housing markets and impact a growing number of low-to-moderate income citizens. Thus, Scott (2010) has advocated the need for legislative reform policies including rent control, tenant protection programs, and subsidy programs for landlords and developers to provide client protection and increase affordable housing.

Currently, Ontario, British Columbia, Manitoba, Prince Edward Island and Quebec have rent control policies and New Brunswick, Nova Scotia, Ontario and Manitoba have implemented tenant protection programs such as “security of tenure” legislation to prevent tenants from being evicted without reasonable cause. In Nova Scotia and New Brunswick, legislation protects tenants from unjust eviction if they have resided at a residence for a period of five years after which time they are granted “tenure” and landlords may not give eviction notice except in the case of a natural disaster such as fire or flooding (Scott, 2010).

Tenant protection policies are an effective mechanism to lower eviction rates and therefore reduce the number of people competing for rental properties. The province of Ontario has introduced protection policies that stipulate tenants have “first right of refusal” which means if a property must be vacated for renovations or repairs, tenants whose rental agreement was terminated during the construction period have first priority to return to their former residence without an undue increase in rent. Ontario also stipulates a maximum of one rental increase each year to account for inflation and property owner expenses (Scott, 2010).

Scott (2010) also states offering subsidies to landlords, property owners and developers help to provide and maintain affordable housing stock. A wide range of subsidy options include tax credits, rebate programs, subsidies for renovations, financial incentives for designating a percentage of housing units for affordable housing, and the formation of “housing trust funds” to assist in financing affordable housing projects and to assist low-income renters.

Subsidy programs also help offset any shortfalls in financial returns for landlords and property owners as a result of rent control policies or tenant protection programs and ensure operating and maintenance costs are sustainable (Scott, 2010).

Housing Strategies in Canada

Provincial and Municipal Strategies

Several provincial and municipal governments have developed plans and strategies to guide the allocation of funds from both federal and provincial coffers. These plans and programs are briefly summarized below, arranged from west to east.

British Columbia

Since 2004, the BC Government has implemented a number of provincial homelessness initiatives. These include:

- 1) The Affordable Housing Initiative, which allocated in excess of 4,000 units since its inception (BC Housing, 2009)
- 2) Housing Matters BC, a provincial housing strategy committed to existing and new approaches to meet the needs of the homeless in a changing housing environment (Housing Matters BC, 2007)
- 3) Breaking the Cycle of Homelessness Initiative, developed from the two earlier initiatives, included an annual commitment of \$41 million to sustain emergency shelters, expand outreach to the homeless. Its focus was on Aboriginal persons, rent supplements, and fast-track approvals of housing applications (BC Government, 2009)

Vancouver

Vancouver is governed by both the City of Vancouver and Metro Vancouver, each of which has been involved in developing local strategies. Research highlights the following initiatives:

1. Supporting Community Partnerships Initiative (SCPI) focused on the continuum of supports for people who were homeless and on the streets, from emergency and transitional housing through to independent housing. Based on three key elements: affordable housing, adequate income, and support services; its specific goals included: enhanced continuum of housing and support; creation and maintenance of a continuum of housing; promotion of income adequacy for households; promotion of support services delivery; and support for sub-regions in the greater Vancouver area to meet local needs (Social Planning and Research Council (SPARC), 2003).
2. Affordable Housing Strategy identified a number of critical housing challenges: demand for affordable rental and ownership housing, low vacancy rates, low levels of new rental housing supply, loss of existing rental housing units, an increasing socioeconomic gap between tenants and owners, and an increasing incidence and duration in homelessness across the region. The program developed a report that called on the federal government for a National Affordable Housing Strategy making federally-owned land available for affordable housing development. This same report further recommended that financial support continue to be provided at increased levels to address homelessness (The Standing Senate Committee on Social Affairs, Science and Technology, 2009).
3. Homeless Emergency Action Team (HEAT) implemented in 2008, identified immediate action steps that the City and its partners could take to get the homeless off the street and into safe and secure shelter over the winter.

4. Metro's Affordable Housing Strategy encouraged the federal government to develop rental housing through tax treatment, to increase funding, and to enhance RRAP to improve access to funds (The Standing Senate Committee on Social Affairs, Science and Technology, 2009).

Alberta

In February 2007, the Alberta Government appointed the Alberta Affordable Housing Task Force, with a mandate to focus on solutions for homelessness and affordable housing, to include rent subsidies and home ownership. It offered immediate- and longer-term solutions, mostly with respect to housing affordability, rather than homelessness. Its immediate-term recommendations included increasing funding to emergency shelters, establishing an Alberta Transitional Housing Initiative, increasing capital funding for affordable housing construction, an eviction prevention fund, and an increase in the shelter allowance for people on income assistance (The Standing Senate Committee on Social Affairs, Science and Technology, 2009).

The Alberta Government also completed a report for the federal government that provided a number of recommendations supporting affordable housing (Alberta Affordable Housing Task Force, 2007). In its 2007 budget, the Government of Canada replied with a \$285 million funding commitment to the following:

- Modifications to the GST,
- Treatment of new homes and non-profits' capital and operating costs,
- Extensions and acceleration of capital cost depreciation,
- Substantial increase in funding, and the creation of a national housing strategy (Alberta Affordable Housing Task Force, 2007; The Standing Senate Committee on Social Affairs, Science and Technology, 2009).

Following this commitment in 2008, the Alberta Secretariat for Action on Homelessness was appointed with a mandate to develop and implement a provincial plan, which included rapid re-housing of homeless Albertans, moving them from streets and shelters into permanent housing; providing client-centered supports to re-housed clients, helping them obtain the assistance they need to restore their stability and maintain their housing; and preventing homelessness through emergency assistance and by providing adequate and accessible government programs and services to Albertans (Alberta Secretariat for Action on Homelessness, 2008).

Edmonton

Edmonton has been involved in housing and homelessness issues since 1999. To qualify for funding under the National Homelessness Initiative, the Edmonton Joint Planning Committee on Housing had formed (Edmonton Joint Planning Committee on Housing, 2000). Since its inception, the following strategies have been formed:

- 1) Low-Income and Special Needs Housing Strategy was based on five principles with respect to access to housing, municipal co-ordination, stakeholder consultation, program delivery, and shared funding responsibility. In particular, the report called on federal and provincial funds—to provide a sufficient supply of housing units that is both physically adequate and affordable to low-income households [and] adequate household incomes and necessary support services.

- 2) Task Force on Affordable Housing focused on options to encourage the construction of new rental housing at any rent level, and measures to encourage an increase in the supply of affordable rental units.
- 3) Edmonton Joint Planning Committee on Housing addresses homelessness, housing and support service needs. Its final report also called for funding from the Urban Aboriginal Strategy, Urban Aboriginal Homelessness Program and other elements of the National Housing Initiative (Edmonton Joint Planning Committee, 2009).
- 4) Cornerstones: Edmonton's Plan for Affordable Housing was a collaboration of all levels of government and community partners to increase income and supports for those in need of emergency and transitional shelter, and to develop 2,500 new long-term housing units. Committed to play an advocacy role with federal and provincial governments, the City of Edmonton was to play a more active role in meeting the housing targets (City of Edmonton, 2009).

This was established by the implementation of a number of grant programs, each with a specific focus: building long-term affordable housing, purchase of existing stock for affordable housing, a municipal fee rebate to offset some of the costs of developing affordable housing, the development of secondary suites, or the piloting of rent supplement programs (The Standing Senate Committee on Social Affairs, Science and Technology, 2009).

The Edmonton Committee to End Homelessness had five goals which were to provide permanent housing options for people living on the streets, ensure an adequate supply of affordable housing, ensure supply of emergency accommodation, prevent homelessness, and establish a governance and implementation process for the plan (The Standing Senate Committee on Social Affairs, Science and Technology, 2009).

Calgary

The Calgary Committee to End Homelessness, a community-based, multi-sectoral Committee, unveiled its 10-year plan to end homelessness, and created The Calgary Homeless Foundation that would be responsible for its implementation. Drawing on evidence-based ideas and programs field-tested and incorporated into similar 10-year plans in the US, following the Housing First Model. This model provided the opportunity to create affordable housing opportunities, while ensuring that necessary supports were put in place. Its specific targets included: eliminating family homelessness in two years; retire 50% of Calgary's emergency shelter beds within five years; achieve an 85% reduction in the chronic homeless population within five years; complete elimination of chronic homelessness in seven years; and reduce the maximum average stay in emergency shelters to less than seven days by the end of 2018 (The Standing Senate Committee on Social Affairs, Science and Technology, 2009).

This would be accomplished through the creation of affordable housing units, which allowed for the creation of secondary suites and student housing (The Standing Senate Committee on Social Affairs, Science and Technology, 2009).

Saskatchewan

The City of Saskatoon administers a number of programs designed to assist housing providers, encourage affordability, and increase the supply of housing in the community. The Saskatoon

Housing Initiatives Partnership (SHIP) is an example of a successful provincial housing policy that enhances and encourages affordable housing project development. SHIP offers support to all types of affordable housing providers that are planning to build affordable housing units in the Saskatoon Region. Services include assisting affordable housing providers with project development, consulting, business planning and housing market research as well as community engagement and addressing “public perceptions” about affordable housing (City of Saskatoon, 2012).

A Task Force on Housing Affordability was formed in 2008 with a mandate to study and make recommendations on three issues:

- 1) To improve housing affordability and security for those least able to afford rising housing costs;
- 2) To increase capacity in the housing system to encourage the creation of affordable housing; and
- 3) To examine how best to facilitate the long term monitoring, policy development and provisions of affordable housing in Saskatchewan

(The Standing Senate Committee on Social Affairs, Science and Technology, 2009).

This work produced 36 recommendations, ranging from increasing income for low-income people in the province to eliminating provincial sales tax on building supplies for affordable housing construction. It further called on the federal government to change tax treatment of income from rental property, and to renew the five-year affordable housing agreement scheduled to expire in 2009.

The Government responded by increasing shelter allowances in all of its income support programs, implemented technical changes to boundaries and income thresholds for rental increases, increasing per-diem rates paid to emergency shelters, and an expansion of the Saskatchewan Housing Authority Board.

Toronto

The City of Toronto established its Street to Home Plan in 2005, with a goal to help homeless people living outdoors to get a safer place to sleep and find long-term housing.

Toronto’s Plan to End Street Homelessness implemented the Housing First Model, an approach which houses homeless individuals directly from the street, providing them with appropriate supports and taking their perspectives into account on the housing process and supports they receive. The findings demonstrated that the vast majority were satisfied with their housing and had seen improvements in nearly all quality of life indicators.

The findings demonstrated that the vast majority were satisfied with their housing and had seen improvements in nearly all quality of life indicators. The study also showed that while individuals faced challenges in making the transition from the streets to housing, the follow-up supports offered by Streets to Homes were helping people to keep their housing (Raine & Marcellin, 2007). While a second analysis of the survey results suggests that the results were overstated in this report, it did not discount the overall positive results (Falvo, 2009). Later in 2008, Streets to Homes was recognized by CMHC as one of the promising practices, with respect to affordable housing (City of Toronto, 2008).

Ottawa

The City of Ottawa developed its goal to end homelessness in 1999. In a report developed in 2005, the City of Ottawa identified its achievements that included the construction of more than 300 new low-income units (including with SCPI funding), the development of a Housing Loss Prevention Network, and improved collaboration among city agencies with respect to homelessness. It further advocated with federal and provincial governments for better social housing, immigration, health and income support policies to prevent and resolve homelessness (The Standing Senate Committee on Social Affairs, Science and Technology, 2009).

This strategy, launched in 2007, established three broad directions consistent with broader policy goals of the City: —building healthy, inclusive, sustainable communities; promoting and preserving affordable housing; and meeting the need for supports to housing (The Standing Senate Committee on Social Affairs, Science and Technology, 2009).

Its final report provided the following recommendations to the federal and provincial governments:

- More comprehensive, integrated programs and tools that promotes local control over policy development and implementation,
- Improved tax treatment of expenditures on rental construction,
- Extended time-lines on funding, and
- Making RRAP a permanent program
- Sustained and sufficient funding for both housing and housing supports, and
- Allowance for increased local flexibility.

(The Standing Senate Committee on Social Affairs, Science and Technology, 2009)

Montreal

The City of Montreal's Master Plan's focus is to construct 60,000 - 75,000 housing units between 2004 and 2014, to provide high-quality living environments and to accomplish three goals: a balanced residential supply, improved housing conditions and living environments and residential development (City of Montreal, 2005). To accomplish same, the following strategies and programs have been implemented:

- 1) The Inclusionary Housing Strategy determined that 15% of all new housing units be affordable and 15% be built by the community and social sectors. Its seven major components consisted of: optimization of current housing subsidy programs; use of municipally owned land; cultivation of partnership with major public property owners; full use of regulatory and planning tools; adaptation of the city's service delivery model; research, development and communication activities; and monitoring implementation (City of Montreal, 2006).
- 2) Urban Housing for Families Program has been initiated as a major commitment towards the Grandir à Montréal' Family Policy. Under this program, a call for proposals was issued to developers to develop more family-friendly designs and layouts, located near family-friendly services.

Newfoundland and Labrador

In 2009, the Newfoundland and Labrador Government identified its series of strategic priorities for social housing. These include:

- 1) Preserve privately owned homes by assisting with the cost of essential repairs;
- 2) Provide quality, affordable rental accommodation through direct delivery programs and partnerships with the non-profit and private sectors;
- 3) Promote the development of more new affordable housing;
- 4) Support home modifications to address the accessibility needs of seniors and persons with disabilities;
- 5) Promote renovations for lower-income homeowners to improve energy efficiency and conservation;
- 6) Preserve homes to ensure they meet current and future housing needs while improving overall energy efficiency during renovations; and
- 7) Work with government and community partners in the develop of a range of housing options which will prevent homelessness by integrating housing and other services to promote housing stability.

Newfoundland and Labrador Housing, 2009

Like other provincial governments, the Newfoundland Labrador government also identified a number of challenges in social housing: changing demographics, aging housing stock, pressures in the private market, increasing need for integrated support services within housing and flagging federal operating funding (Newfoundland and Labrador Housing, 2009).

In its final report, Newfoundland and Labrador Housing (2009) called on the federal government to provide a long-term funding commitment to address these social housing challenges, through collaboration and funding, and respect to meeting the housing needs of Aboriginal peoples.

International Housing Policies and Legislation

Internationally, France, Sweden and the Netherlands all have some sort of rent control policies guiding their housing markets. Research suggests that the most unconstrained housing systems can be found in countries with liberal social policies such as Switzerland, Belgium, Australia, Great Britain and the United States (Scott, 2010).

Housing Policy in the UK

An international survey on housing policies and homelessness found England to have a unique housing policy where homeless families and individuals have “legally-enforceable rights” to indefinite temporary housing until suitable permanent housing can be found. Scotland also has housing legislation that states that temporary accommodation and permanent re-housing is a right for qualified homeless households (Communities and Local Government, 2006).

In the United Kingdom, these housing policies form a legal framework that encourages and obliges local authorities to provide permanent housing as a long-term response to homelessness for people in priority need. The Supporting People Program in the UK provides temporary accommodation accompanied by broader assistance programs including support services to allow individuals to acquire employment, financial and social skills to help achieve their independence (Communities and Local Government, 2006).

Housing policies also affect the severity and length of homelessness by reducing the number of households falling into homelessness and by rapidly addressing homelessness when it occurs. Prevention and early intervention strategies such as family counseling, landlord-tenant mediation, housing advice services and the provision of rental deposits were also found to make a significant difference to the number of households and individuals becoming homeless. In addition, the provision of appropriate support services for households needing assistance can help to prevent and resolve homelessness (Stephens et al., 2007).

Improving Social Housing in the UK

Shelter, a housing and homeless charity in the UK, advocates for secure, affordable social housing that enables people to find and maintain employment, establish roots and become a part of their community. To help ensure the sustainability of the UK's supply of social housing, Shelter has identified the need for the following housing policies and calls on the Government to:

- **Build more social housing:** To ensure the Government follows through on its recent commitment to build more new, appropriate and affordable social rented homes.
- **Protect and improve current social housing stock:** Shelter states the Government must continue to invest in and improve the quality of current social housing units and recommends the Government re-examine its policy of allowing current tenants to buy the social housing that is their current residence. Preserving an adequate supply of social housing stock is necessary to ensure that those requiring social housing are able to access it.
- **Update community planning:** To encourage planning that moves away from the practice of building separate social housing estates, such as those built 30 to 40 years ago. By integrating social housing alongside private housing developments and not concentrating tenants with social and economic needs in the same area provides opportunities for residents to form viable, mixed communities.
- **Preserve secure tenancies:** Shelter opposes any changes to current legislation on social housing that would see fixed time periods for social tenancies and conditions imposed on tenants to actively seek employment while residing in social housing. While this is seen as a way to "increase social mobility" and thus increase vacancies, the housing and homeless charity disagrees with these changes on the grounds they would "undermine the stability of communities" and increase homelessness.
- **Improve housing advice and support:** By improving housing advice and support for people who are eligible for, or already living in, social housing will help ensure that those in need can understand and navigate the housing system. Advice services can be provided through a variety of channels including in-person assistance through casework or at "advice centers," online web-advice sites, toll-free help lines, outreach to peoples' homes as well as hospitals and correctional facilities.

Housing Policy in Germany

In Germany, the responsibility for housing policy resides within the federal system and is shared by all three levels of government, the Federation, the Länder, or states, and the local authorities (Ammann, 2010).

In addition to establishing a "principal legal framework", German federal housing policy also influences housing market conditions through measures such as financing, subsidization, rent regulations, tax law, approval procedures, construction planning and building regulations in close co-operation with the states. National laws specify subsidies, such as housing benefits and

housing supports but leave “extensive latitude” to the states to define target groups and subsidy levels as well as to specify the approval and payment of subsidy funds for disadvantaged populations.

As of 2006, subsidies for rental housing are the sole responsibility of the states. Municipal administrations are responsible for the needs of local low-income and at-risk households including housing benefits, the designation of land for affordable housing construction and the provision “technical and social infrastructure” (Ammann, 2010).

In Germany, the average “rental burden” – the amount of gross household income renters spend on housing – was 25.5 percent in 2005 with Munich, Stuttgart and Frankfurt having the most expensive rental markets (Kofner, 2011). Residential rental construction is supported by economic incentives such as “tenant subsidization” which provides housing benefits to less affluent households, “property subsidization” which provides social housing support for rental accommodation housing, and tax subsidies for those investing in rental housing. Home ownership incentives are also available with low interest rates and loans for the purchase, renovation or construction of housing (Ammann, 2010).

Rental laws also affect the housing markets by capping limits for rent increases. These housing policy measures are supported by a variety of urban development subsidization, such as urban development support and environmental policy aspects of housing including energy-saving regulations. These measures not only help increase the supply of affordable housing and improve the residential environment, but also ensure lower energy consumption and sustainable housing development (Ammann, 2010).

Housing Market Conditions in Germany

Germany has been shown to maintain an unusually large amount of quality, private rented housing due to “generous fiscal support” (Directorate General for Research, 1996). Despite a decline in the construction of new housing since peak levels in 1996, research states there is currently a “plentiful supply” of rental housing in Germany. This has been attributed to the willingness of private owners, housing cooperatives and builders to become involved in rental housing construction due to high levels of subsidization for the construction of social rental housing. In addition, most of the larger towns in Germany own their own municipal housing companies, who together with the housing cooperatives, own as much as 15 percent of the housing stock. The co-ops and municipal housing companies are important partners in providing social housing support and accommodation to low-income households (Ammann, 2010; Kofner, 2011).

In addition to an adequate supply of rental housing, disadvantaged populations also benefit from rental legislation that ensures fair and equitable treatment in the interests of tenants while respecting the “ownership rights” of landlords. Rental laws protect tenants from unjust evictions, lease terminations and “arbitrary rent increases” while owners and landlords can ascertain the profitable management of their business by applying for rent increases based on comparable properties, professional assessments and reference to local rental information from a rent registry database maintained by the local municipality or housing association (Ammann, 2010).

Housing Policy Subsidization

Housing benefits are an essential component of housing and rental policy and are integral to lessening the impact of fluctuations in the supply and demand aspect on the housing market, particularly for lower-income households. Housing benefits are paid equally by both the federal government and by the states and depend on the combined household income, the amount of rent that qualifies for rent support and the size of the family or household. Housing benefits are paid as a rent allowance to tenants. Households receiving benefits are not restricted to living in low-rent properties but instead, are encouraged to access housing with average rents in order to create and maintain “stable resident structures” throughout the residential districts (Ammann, 2010).

Social Housing Support

Germany has developed policies for unique circumstances in their provision of social housing support. Ammann (2010) points out that the majority of social housing comes from public subsidies to private landlords and owner-occupiers, with the remainder supplied by municipal housing companies. Social housing support provides low-cost rental housing to low-income households, especially families with children, and households experiencing difficulties accessing the “general housing market” including single parents, pregnant women, the elderly and the handicapped.

Social and public housing in Germany is in “constant descent” due in part to aging housing stock and privatization. This increases the importance of private rental housing in the marketplace with most subsidies for rental housing geared towards energy efficiency and modernization (Kofner, 2011). Through the Federal Housing Act, the federal government specifies the housing support principals and shares funding with the states. One form of subsidization is paid directly to landlords who agree to rent housing only to households with a “housing entitlement certificate”, issued by the state to qualified applicants whose overall household income limits are not exceeded (Ammann, 2010).

Social Housing Policy in the Former East Germany

Social housing policies ensuring balanced and stable conditions for housing markets in the states of the former East Germany also present challenges. Here, municipalities are confronted by problems with poor quality housing stock that require continued renovation, with the additional need to modernize entire districts with sub-standard housing. The “Urban Renovation for the East” Program has subsidized the “clearance” of up to 400,000 dwellings, which are unsuitable or no longer needed, with a view to regenerate and stabilize the housing markets in the former east block. This demolition of housing stock is closely related to the subsidization policy of debt relief for housing companies in the former eastern block. Housing companies had over 14 billion Euros of debt relieved as long as they sold at least 15 percent of their housing stock – primarily to tenants (Ammann, 2010).

The Role of Housing Cooperatives

Recent housing policy in Germany has identified the revitalization and strengthening of housing cooperatives as a priority in the 2002 Housing Subsidization Act to guide social housing construction and other initiatives. For over 100 years housing cooperatives have provided high quality housing at reasonable terms. Currently, cooperatives play a “static role” in the housing market and have a disproportionate number of older tenants. However, over 3 million co-op members are drawn to the benefits and advantages that these secure, long-term housing

investments provide, which include joint ownership and owner self-determination. Housing cooperatives offer a viable alternative between the rental housing market and home ownership and have been referred to as the “third pillar” of housing supply next to owner-occupancy and residential rentals. Housing co-ops currently make up 6 percent of the housing market and will increase as a result of becoming an important housing policy objective of the federal government (Ammann, 2010; Kofner, 2011).

Future Housing Policies and Initiatives

A key aspect of Germany’s housing policy is a joint initiative introduced by the German Energy Agency to provide information and assistance to clients, homeowners and other stakeholders on the construction and refitting of energy-efficient buildings including interest rate subsidies and investment grants. The “Future House” Initiative brings energy-efficient building and renovation techniques to the attention of planners, architects, the building industry and end-users. A similar program has been unveiled as a model project called “Low-energy house for existing stocks” in a partnership between the German Energy Agency and Construction and Urban Development. The project aims to examine “innovative technical standards” to determine practical and “economically viable” recommendations for future housing renovation methods (Ammann, 2010; Kofner, 2011).

Housing Policy in Finland

Once centrally driven, the housing policy in Finland has become “more fragmented”. Formerly governed by the National Housing Board (NHB), the administration of housing policy was decentralized in the 1980s, with functions transferred to a separate Housing Fund under the Ministry of the Environment who had the responsibility for the distribution of subsidized loans and housing allowances among local authorities. Local authorities are also responsible for local planning, housing programs, land purchasing and the administration of housing loans (Directorate General for Research, 1996).

The cost of housing policy in Finland is “quite low by northern European standards” amounting to the equivalent of about two percent of GDP in 1994. The largest costs are associated with housing allowances and “mortgage interest tax relief” for owner occupiers. Approximately 10 percent of households received housing allowances in 1996 (Directorate General for Research, 1996).

Tenure Structure and Trends

Finland’s urbanization in the past 40 years has resulted in high rates of housing production, which exceeded 10 units per 1,000 inhabitants. The vast majority of housing is owner occupation (72%), social rented (14%) and privately rented (11%). Recently, the long-term trend has seen a reduction in the private rented sector and the growth of the owner occupation and the social rented sector. Having once been in long-term decline operating “under the burden of rent control” in Finland, rental housing has been heavily supported by state subsidized loans and the private rented sector is now “being targeted for growth” as a growing number of young people enter the housing market (Directorate General for Research, 1996).

Key Policy Challenges

Finland’s housing policy was impacted by the economic crisis experienced in the early 1990s. As a result of the “collapse in trade with the former Soviet Union” Finland experienced fiscal

restraint, large government subsidies, unemployment, devaluation and a reduction in their housing budget. In the 80s and 90s, a housing price boom and a recession created a lack of confidence in the housing market which created a shortage of rental housing, especially in the free market sector. The government established policies to help young people buy housing and “deregulated rents on new tenancies” to help increase the supply of rental housing (Directorate General for Research, 1996).

Socially-mixed housing has always been an important component of Finland’s housing market. It has been maintained by policies to provide housing subsidies and maintain “high design and construction standards” for rented social housing that emphasized small scale, mixed developments. This policy produced socially-mixed developments while providing housing for people in need. It greatly helped to reduce the “easily identified and stigmatized” rental social housing estates often found in other European countries (Directorate General for Research, 1996).

Finland has also set aside housing funds for special needs groups including a separate “housing allowance system for the elderly” and renovation funds to adapt houses. This funding also countered a growing unemployment problem by creating employment with the promotion of large scale renovation programs. In 1994 one out of every 10 houses were renovated and improved with state funding (Directorate General for Research, 1996).

Policy Responses to Homelessness

Homelessness is a “significant component of social exclusion” in the European Union. While Finland has a “relatively low” homelessness problem by international standards, they have introduced a number of measures that address this problem. These include the provision of:

- Loans to municipalities and local organizations to construct and purchase housing for the homeless
- Supporting apartments for homeless people with varied levels of support for mental health patients living in the community, from fully-supported living to independent living (Directorate General for Research, 1996).

HOUSING AND SUPPORT INITIATIVES: JURISDICTION REVIEW

United States

History of Housing Initiatives

The U.S. has seen a number of innovations in housing initiatives in the last two decades, due to the move towards more systemic and contextual perceptions of the causes of homelessness, driven by research and by opportunistic housing initiatives, many of which have been originated by people who were formerly homeless or suffered from addiction and/or mental illness.

In New York City, two pioneering housing experiments were Fountain House and Pathways to Housing. Fountain House was the first “Clubhouse”, an intentional community for men and women with histories of psychiatric illness. Fountain House began in 1948 and emerged from a group of former psychiatric patients who were meeting informally and recognized the importance of a non-institutional community in the process of recovery (<http://www.fountainhouse.org/content/history-timeline>). In 1958, Fountain House began to secure leases for apartments in the community and the leases were often signed personally by members of the board. The next year, the National Institute of Mental Health awarded Fountain House a research grant to compare outcomes of people in Fountain House to those who did not receive services from the program. This was the first documented experience of persons with severe mental illness recovering and even flourishing in a community setting.

In 1990, the New York-New York Agreement was signed by the mayor of NYC and the governor. This was in response to a scarcity of housing for homeless persons with serious mental illness. Housing models developed under this agreement covered a variety of models along the residential continuum and allowed researchers to conduct “naturalistic” studies of tenure in housing and the factors affecting residential stability (Lipton, Siegel, Hannigan, Samuels, & Baker, 2000). As well, the McKinney research demonstration programs for homeless persons with serious mental illness sponsored by the National Institute of Mental Health supported five experimental studies in four cities (Shern, Felton, & Hough, 1997), similar to the demonstration projects currently sponsored by the Mental Health Commission of Canada. Data began to emerge that “housing is a potent catalyst for recovery” (Mental Health Commission of Canada, 2010).

These initiatives led to a New York housing project called Pathways to Housing. This marked the beginning of the Housing First movement. Pathways to Housing is based on the premise that housing is a basic human right and cannot be denied to anyone. The Pathways to Housing program introduced the delinking of housing and supports. This was the first published source of data on a Housing First approach. Its primary assumption is that although housing and treatment are closely linked, they are considered separate domains, and clients in the program may accept housing and refuse clinical services altogether without consequences for their housing status. There are 2 program requirements: tenants must pay 30% of their income (usually Supplemental Security Income [SSI]) toward the rent by participating in a money management program, and tenants must meet with a staff member a minimum of twice a month. Since its inception, Pathways to Housing has made two modifications. Assertive Community Treatment [ACT – described in the Housing and Support Models section] remains a key support component but a nurse practitioner was included to address the considerable

number of health problems, and a housing specialist was added to coordinate the housing services. These requirements are applied flexibly to suit clients' needs. Research found that 88 per cent of those housed through the Pathways program retained their housing for two years compared to 47 per cent in the continuum of care model. After four years, housing retention rates remained higher in the Pathways to Housing program compared to treatment as usual (Tsembiris S, 2004).

When clients are surveyed, they universally prefer independent living and support that is available but not intrusive (Nelson, Hall, & Forchuk, 2003).

Housing and Support Examples

Three housing initiatives in the U.S. have received significant attention.

Pathways to Housing, New York, NY:

- Clients are offered choice among up to three apartments
- The Housing Department and Assertive Community Treatment [ACT] team members work with clients to find an acceptable living accommodation
- Scattered-site housing through private landlords
- Limited number of clients housed in any building to encourage community integration
- The program holds the lease and sublets to the client
- Clients choose the array and sequencing of ACT support services
- No requirement for treatment or sobriety

DESC (Downtown Emergency Service Center, Seattle, WA)

- The program owns or controls the housing
- The program also serves as the primary service provider
- High level of supervision, staffing is on-site
- Housing is within a small number of buildings in a limited area, minimizing client choice and community integration

REACH (Reaching Out and Engaging to Achieve Consumer Health), San Diego, CA

- While there is no exclusion criteria related to treatment or sobriety, many of the housing options have restrictions on substance use
- REACH program staff will help clients to maintain permanent housing
- Scattered-site apartments

(Pearson, Locke, Montgomery, & Buron, 2007)

In 2010, the U.S. federal government approved a plan to end chronic homelessness in 5 years, to prevent and end homelessness among Veterans in 5 years, to prevent and end homelessness for families, youth, and children in 10 years and to “set a path to ending all types of homelessness” (United States Interagency Council on Homelessness, 2010).

In Washington State, planning teams in King, Pierce, and Snohomish counties—the three most densely populated counties in the state—have just completed comprehensive plans to re-design systems and services to best meet the needs of at-risk and homeless families. Their plans are

rooted in five key strategies:

- Prevention: Keeping families that are on the edge of homelessness housed and linked with the right services
- Coordinated Entry: Implementing a common way for families to access homeless services and for providers to quickly link families to the resources they need
- Rapid Re-Housing: Moving families rapidly into permanent housing, when- ever possible
- Tailored Programs: Getting the right services at the right level—and at the right time—for each family
- Economic Opportunities: Creating stronger connections to family-wage jobs for the recently homeless

(Building Changes, Policy Paper, 2011)

A recent review of the evidence examined housing interventions and its efficacy, particularly the impact on determinants of health. It found “sufficient evidence” for the use of rental vouchers, which allowed the recipient to choose from private- or public-market opportunities and reduced exposure to risks such as homelessness, overcrowding, malnutrition and poverty. Other promising evidence that the reviewers considered needed more testing were:

- Health impact assessments: use of procedures, methods and tools to judge the potential effects, direct or indirect, of a policy, strategy, program, or project on the health of the population
- Moving to Opportunity Demonstration Program: Relocation to Low-poverty neighbourhoods: adults and children reported increases in perception of safety and reductions in observing and being victims of crime and they reported improvements in their mental health, including reductions in psychological distress, depression and anxiety
- Smart Growth and Connectivity Designs
 - Design of housing communities allowing easy access to services and community resources
 - Mixed land use, higher density, diverse neighbourhoods
 - Complexity of factors influencing physical activity and mental health or stress require additional research to verify links
- Zoning
 - While some zoning and land-use policies have segregated neighbourhoods, when combined with thoughtful city planning and community input, zoning codes can protect the health of individuals and reduce health disparities

(National Center for Healthy Housing, 2009)

A 2010 report on the Federal Collaborative Initiative to Help End Chronic Homelessness, which funded 11 sites to expand permanent supported housing, examined qualitative data on three housing approaches for rapid placement of clients: scattered units, congregate or clustered, and a combination of these, called mixed unit housing. There was an effort made to encourage and facilitate collaboration between housing or property management personnel and support services staff. Results suggested that a mixed housing approach allowed for flexibility with a range of housing configurations. This suggests that every client is unique and, despite the general outcomes supporting independence and scattered sites in other studies, the availability of diverse housing options seems to offer the most help. Another important lesson from this project was the critical integration of property managers and housing specialists as joint

members of the project teams. There were also a number of unexpected and unbudgeted costs that accompanied the need to keep clients housed (i.e., utility costs, furniture, damage).

Based upon the collective experience of many different providers of supported housing, as well as upon the suggestions of people in related industries, one group in the U.S. identified strategies for both enhancing the design process, as well as design features that can help improve the final “product” and result in higher-quality supported housing projects. They are:

- Input of Partners and Stakeholders is Essential to Success
- ‘Buildings with a Mission’ Can Inspire People and Create Lasting Interest
- Well-Chosen Design Features and Materials Can Help Achieve Diverse Objectives
- Addressing Tenants’ Needs for Independence and Privacy
- Designing Common Spaces to Encourage Interaction and Community
- Designing Safe and Secure Living Environments (Corporation for Supportive Housing Illinois Program, 2009)
- Housing and services should be integrated to enhance the social and economic well-being of residents and to build healthy communities.
- Residents, owners, property managers, and service providers should work as a team in integrated housing and service initiatives.
- Programs should be based on assessment of residents’ and community strengths and needs, supported by ongoing monitoring and evaluation.
- Programs should strengthen and expand resident participation to improve the community’s capacity to create change.
- Resident participation in programs should be voluntary, with an emphasis on outreach to the most vulnerable.
- Community development activities should be extended to the neighboring area and residents.
- Assessment, intervention and evaluation should be multilevel, focusing on individual residents, groups, and the community.
- Services should maximize the use of existing resources, avoid duplication and expand the economic, social and political resources available to residents (Collaborative Solutions Inc, 2008).

Australia

The hub of housing research in Australia is the Australia Urban Housing and Research Institute (AHURI). AHURI’s mission is to deliver high quality, policy-relevant evidence for better housing and urban outcomes. Its strategic goals are to:

- Strengthen policy relevance.
- Ensure high quality research.
- Improve research accessibility.
- Foster dynamic collaboration.
- Support and strengthen research capability.

AHURI funding is received from three sources: grants from the Australian and all state and territory governments; contributions from universities; and third parties.

To date, Australian homelessness responses have been primarily crisis-based, although a recent Green Paper is attempting to coordinate efforts and includes the goal of halving homelessness by 2020. This is a modest goal compared to other jurisdictions.

There are some questions about the transferability of Housing First programs to the Australian context and researchers have expressed some concern that clients in the Pathways program in New York described continuing to feel marginalized and excluded (Johnson, Parkinson, & Parsell, 2012). Australia's supported housing services are called Specialist Homelessness Services (SHS), formerly known as the Supported Accommodation Program. These services target a broad range of people and do not require people to receive treatment or make changes prior to allocation of housing. However, Australian services could provide more timely access to permanent housing options.

In considering the transfer of supported housing models to Australia, it can be an opportunity to determine what should be transferred; a core set of operational elements (the critical ingredients), a philosophy or a combination of both. These issues raise two salient questions. First, should there be a 'standard' Housing First model or set of operational standards to which all Housing First services should conform? And, second, how can the tension between program fidelity and adaptations to local conditions be best managed to ensure that program outcomes remain high quality, measurable and comparable (Johnson, Parkinson, & Parsell, 2012)?

Europe

In Europe, the Housing First approach to homelessness is currently being tested in a number of cities and some evaluations are going on at the local level already. Housing First Europe started 1st August 2011 and is planned to last for 24 months. It will test and evaluate Housing First projects in five European cities, leading to greater clarity about the potential and the limits of the approach, as well as the essential elements of Housing First projects. It will also facilitate mutual learning with additional partners in five "peer sites" - cities where further Housing First projects are planned. Differences in existing Housing First approaches will be discussed and analysed: for example the role of choice, the type of housing provided (scattered site versus congregated housing), the type, duration and intensity of support provided. The difficulties and successful approaches of support agencies to get access to regular housing, to manage financial risks for service providers and other issues will be documented. It is planned to develop recommendations for dealing with typical challenges of the approach, including:

- Relapses of service users into street life
- Neighbourhood complaints
- Non-payment of rents
- Unmet support needs and rejection of support
- Social isolation
- Worklessness
- Substance abuse

The project will attempt to reach conclusions about the possible use of the approach on a wider scale (Busch-Geertsema, 2011).

France

In France, “A Home First” program is being run on four sites - Lille, Marseilles, Toulouse in 2011 and Paris in 2012. It has an experimental component, and a research and evaluation component. Two hundred volunteers will be recruited on each site according to three criteria: homelessness, severe mental disorder and high-level support needs. Of these 200 people, 100 will go into the experimental program while the other 100 will carry on in mainstream provision as the control group (Regnier et al., 2011).

Finland

Finland has established a very ambitious national strategy. The timelines for its homelessness strategy are very aggressive. In February 2008, the Finnish Government adopted a program aimed at halving long-term homelessness by 2011.

The program supports projects that procure supported housing for recently released prisoners and for young people at risk, and prevents evictions, (i.e. by providing and expanding housing advisory services).

Based on the “housing first” principle, which considers that appropriate accommodation is a prerequisite for solving other social and health problems, the program included an ambitious goal to convert all traditional short-term shelters into supported housing units that facilitate independent living. A total of 1,250 additional homes, supported housing units or places in care were expected to be made available.

The program is based on a comprehensive partnership approach between the central government, which provides 50 percent of the program’s financing, and the country’s ten largest cities affected by homelessness, which fund the remaining half. Financial support for the basic renovation of shelters and their conversion into supported housing units is also provided by third parties (the majority of funding for the conversions is coming from profits from the Finnish Slot Machine Association).

A Peer Review has been established that will seek to assess the program’s success and to exchange experiences with countries that are implementing or preparing similar national programs or strategies to reduce long-term homelessness.

Under the Finnish program, much greater emphasis has been placed on the prevention and reduction of homelessness. For example, traditional shelters are reconverted into small apartments, which can be rented with normal tenancies for permanent occupation.

Results of the program to date are that quantitative targets have been met. Of note, it took some time to persuade some of the Non-Government Organizations [NGOs], especially those with leadership from abroad, like the Salvation Army, to get on board, but eventually they did. When the program is complete, in 2012, there will be no more shelters and hostels designed for temporary housing of the homeless in the metropolitan area. They have been replaced by supported housing units based on tenancy. The impact of the “Housing First” principle for long-term homeless people facing multiple problems was reportedly positive. It was stated that the arrangement of permanent housing has awakened the motivation for rehabilitation and that this has led to “an appreciable reduction of alcohol consumption”. Evictions were reportedly rare and exclusively caused by client violence. The belief that the ‘hard core’ homeless (with

multiple problems) would need constant support was not found to be the case in practice. There was, however, an obvious need for greater flexibility of support and some groups would need greater attention in the next phase, such as homeless persons released from prison who are reluctant to use the services offered to them, young people with serious health and drug problems, immigrants and homeless people with a history of debts who have accumulated rent arrears in the past and face barriers in accessing social housing.

The goal of reducing homelessness by 50 percent by 2011 will not be met. The rate of homelessness actually increased in 2009 due to the economic recession. The count is now decreasing but not at a rate that will meet the original target (Busch-Geertsema, 2010).

United Kingdom

A recent review of the evidence for supported housing noted that “existing funding for housing support services will be subject to very heavy cuts for several years. All housing support services will therefore have to justify their costs both in terms of providing good outcomes for service users and increasingly in terms of how they can help reduce costs for other services, particularly National Health Service [NHS] clinical services”.

The reviewers made it clear that, with the increased scrutiny on cost-effectiveness and the economics of housing and supports, research on outcomes will need to emulate the robust nature of U.S. studies. The UK has not developed a strong knowledge base when it comes to social supports. Many of the programs that have been developed over the last decade will be in some jeopardy without clear demonstrations of their impact (Pleace & Wallace, 2011).

“Supporting People” is a program launched UK wide in 2003. The services provided through the program are designed to help vulnerable people with complex needs develop the skills and confidence necessary to live independently without support or to maintain independent living with ongoing support. Support is provided to single people and families enabling them to develop essential personal, social and financial skills.

In Wales vulnerable people eligible for the program will come from the following groups:

- People fleeing domestic violence
- People with learning difficulties
- People with mental health problems and/or drug or alcohol dependency
- Refugees
- People with physical disabilities
- Young single homeless and care leavers
- Ex-offenders
- People who are homeless or potentially homeless
- People with chronic illness including AIDS, AIDS related conditions or who are HIV positive
- Vulnerable single adults who require support

As with many European studies, the published literature expresses caution regarding the generalizability of Housing First outcomes in the U.S. to the United Kingdom context. One review of the evidence, by South Wales Public Health, indicated that the U.S. programs studied

were diverse, with “differences in philosophy, the way in which people were recruited and the types of housing and support provided”. The Welsh review also encountered different definitions of homelessness and stable housing (Price, 2010).

As with Europe, generalizability of approaches to housing does require scrutiny. However, some authors have noted that, while the UK has been innovative in residential and community-based alternatives to long-term institutionalization (Mansell et al., 2007), the NHS has been very cautious in exploring options such as Housing First and intensive supports such as Assertive Community Treatment [ACT], preferring to include them as an addition to a “menu” of options aimed at those for whom shared or transitional models have not worked. It has also been noted that, as in the European experience, there has also been reluctance to move away from “staircase” or “housing readiness” models, particularly traditional, faith-based NGOs (Fitzpatrick, 2012).

The current mainstream system in the UK continues to marginalize the needs of people who have challenging problems and who need long-term support in permanent housing. Over time these patients have been defined as “difficult to place” and some authors argue that this is not because their behaviour is necessarily difficult to manage but rather that existing models of supported accommodation have failed to take account of their needs, based as it is on an assumption that patients will inevitably progress and require fewer services over time (O'Malley & Croucher, 2003).

Home Link is a project established at the time that the “Supporting People” policy was established. This project emphasized secure tenancies and ongoing support. The project also attempted to facilitate the development of informal mutual support among tenants. Support workers provided a range of practical assistance from help with household finances to helping people decorate their homes. These workers were “intentionally” not qualified mental health workers “to avoid a medical emphasis”. The workers spent an average of five to six hours with each tenant each month (O'Malley & Croucher, 2003).

The evaluation of Home Link identified a number of positive outcomes for users including: health benefits such as reduced anxiety and improved mental health; the attainment and maintenance of independence; good relationships with support workers; and opportunities for residents to meet socially.

The support workers were able to provide flexible and diverse forms of support that were valued and tenants wanted this to continue on a long term basis. The only aspect of the scheme that had not been achieved in the way originally planned was the development of informal networks between tenants outside the planned social events.

The widespread use of “floating support workers” has been very effective in the UK. This involves linking the support with the individual rather than a specific location or service. A high level of demand and satisfaction with these services has been reported (O'Malley & Croucher, 2003).

The UK has recognized the need to address the specific issues that are emerging with a growing street homeless population comprised of migrants from the Eastern European States. However, the programs available are designed to provide individuals with support in the service of helping

the migrant return to their country of origin. There are insufficient programs or services to provide supported housing for migrants who want to stay in the UK.

“Shelter” is a UK government supported non-profit organization that targets the ‘street homeless’ across the UK. Shelter funded a consultation with 250 street homeless individuals and also a report on current practices to determine where gaps might exist between the homeless expressed needs and existing services. This report found that most services focused on helping people to escape street homelessness, usually within a limited period of time. But for some, this approach was not working. Too many people were either unable to engage with services, or failed to comply with rules and targets that were conditional to the services provided. The “Good Practice Report” described some projects that were working in different ways to address the problem and the findings reflected some of the ongoing service gaps in the UK (Byrne et al., 2008).

- Housing First
 - To test the applicability of Housing First in the UK, Shelter funded a study of the **Bridge Project** in Exeter run by Bournemouth Churches Housing Association. This was “the closest approximation to a Housing First project” in England. The Bridge Project is unusual in that it houses people straight from rough sleeping into standard social housing units across a number of locations in Exeter. This stands in contrast to the mainstream approach in which rough sleepers move on to self-contained housing only after a successful stay in a hostel.
 - The Bridge Project did differ from the standard Housing First approach: (1) the study found that the project worked best for people who were ‘committed to change’;(2) moving into settled accommodation straight from the street could be a huge ‘culture shock’ for some individuals. Responsive, comprehensive, quality support was needed to help residents make this transition and such support wasn’t always available, and accounted for some people leaving the project.
 - The Bridge Project study suggested that the UK response to homeless complex needs could be quite formulaic or linear: street to hostel to move-on to tenancy. The authors concluded that it is clear this approach did not work for everyone and a range of approaches is needed, including Housing First.
- Wet housing
 - “Wet” and “dry” housing are other terms, respectively, for harm reduction and abstinence.
 - The **Shoreline Project** in Cardiff is an example of housing and support that combines principles of housing first and harm reduction. Shoreline is a mixture of shared houses and self-contained cluster flats aimed at matching clients’ preferences and meeting the Housing First principle that people will only remain in accommodation if it is what they actually want. Existing rules for Shoreline residents concentrate on not upsetting other residents, staff or neighbours. The aim is to make the properties as much like an ordinary home as possible so, for instance, overnight guests are allowed.
 - Support is intensive; each house has a designated worker, there are staff available on a 24 hour basis, and all Shoreline staff have experience of work with street drinkers. Having said this, the method of support is low key, and focuses on developing solutions. This model is based on the principles of

solution-focused brief therapy, the cycle of change, and motivational interviewing. Once off the streets, although drinking does not usually stop, it tends to become much more controlled. All clients have periods of abstinence; for some this may be days, for others, months. In a few cases clients do continue to drink very dangerous levels of alcohol. Clients are aware of the risk and staff will continue to provide support. Clients respect the fact that in the Shoreline Project they are allowed to live and die with some degree of dignity, not alone on the streets. Detoxification is now a planned process and happens at the client's request rather than respite care away from street living. Clients' general health also improves following better access to health services. All Shoreline clients are registered with a General Practitioner [GP]; previously, they would have accessed health services only via emergency departments. Clients also feel they can talk openly about their health with Shoreline staff. This leads to early intervention, as opposed to the deterioration until crisis point that tends to occur with street homeless drinkers.

- **Community Links Personality Disorder Accommodation Service [LPDAS]**
 - The UK has required all support services to ensure that those persons diagnosed with Personality Disorder are able to access the social and healthcare systems. The Community Links charity in Leeds, UK provides support and specialist housing assessments as part of an approach that is intended to meet the housing needs of clients with behavioural challenges in a coordinated and consistent way. LPDAS has designed its own housing assessment tool that focuses specifically on the needs of people with personality disorders. It is a collaborative, holistic and client-centred needs assessment that formulates housing recommendations. The Framework for Understanding Personality Disorder assessment tool is used directly with service users and with front-line workers to aid understanding of their clients' needs. LPDAS also recognises the difficulties that front-line workers can face in trying to provide housing/hostel services for people with personality disorder, and the stress and strain that this can cause and offers training, consultation and supervision.
- Shifting the balance of power
 - **Look Ahead Housing and Care** in London, UK has made a formal practice of including clients [known in the agency as customers to signal the difference in perceptions of power] in the organization and operation of their housing and services. Three linked priorities were established:
 1. Enabling customers to engage in involvement through a training program that takes account of the needs of different client groups.
 2. Extending the range of involvement activities.
 3. A commitment to create a structure of accountability to customers so that they have real influence in shaping the organization at all levels.
 - Look Ahead Housing and Care is unique in its formal operationalization of these objectives. Customers who completed a formal training program would have the skills and confidence to be influentially involved at all levels:
 - Customer Services Committee - Customers have the opportunity to build strong relationships with board members and senior management, and are involved in the scrutiny of performance and quality data.
 - Policy Focus Group - This can influence policies and procedures in a range of areas including drugs, antisocial behaviour, and complaints.

- Staff recruitment - Customers devise questions, sit on interview panels and get involved in inductions.
- Periscope - a customer magazine written for customers, by customers.
- Peer quality auditing
- Look Ahead Housing and Care recognized that transferring power to customers can give rise to legitimate concerns among staff. As part of its implementation of the new involvement program, Look Ahead Housing and Care took great care to consult with staff and deal with their concerns at all stages in the process.

All above examples are from the Shelter Good Practice Report (Byrne et al., 2008).

Canada

National

The Mental Health Commission of Canada has funded a multi-site, randomized controlled study known as the At Home/Chez Soi project. This project is designed to test Housing First interventions through a wide-scale implementation in various settings in five Canadian cities. Recruitment of participants began in 2009 and the project will reach completion by 2013. The study intends to randomize about 2500 participants with either high or moderate need levels into intervention and treatment as usual groups. Outcome measures will be collected over 2 years and will include; housing stability, social functioning and quality of life (Goering et al., 2011).

One of the frequent concerns expressed in the literature may be addressed with the addition, in the overall project, of site-specific intervention components along with a common core protocol. This will allow for exploration of local innovations while maintaining a standardized intervention protocol. This is a rigorous approach and addresses several issues that are pervasive in the literature:

- Model fidelity has been a confounding factor in the majority of reviews of the literature; it has been difficult to know if certain core intervention protocols are consistently followed
- Adapting Housing First and elements of support to local contexts is often done for pragmatic reasons but this study will be intentional about any modifications and innovations to the core housing and support model
- The stratification of levels of need will help to determine whether higher-intense [i.e., assertive community treatment] or lower-intense [i.e., intensive or standard case management] supports can be matched to need with similar outcomes

A more complete description of the study interventions and protocols to ensure quality and fidelity can be found in Appendix B – Best Practices, At Home/Chez Soi Project

As of January 2012, recruitment was complete, with 2234 total participants, 1254 in the Housing First intervention group and 980 in the treatment as usual group. Some information about the participants has been reported in “Early Findings” (Mental Health Commission of Canada, 2012).

- More than 90 percent of participants have at least one chronic physical health problem along with one or more serious mental health problems.
- Brain injury is a common, hidden disability – about 50 percent reported a history of one or more head traumas that knocked them unconscious.

- 36 percent reported having had involvement with the criminal justice system in the last year.
 - Many participants have experienced victimization in the 6 months prior to the study.
- These findings support the majority of profiles of homeless persons in the literature.

Strategies to keep landlords engaged in the project:

- Meeting regularly with landlords individually or as a group i.e., Winnipeg team hosts a breakfast for landlords every 3 months to talk about successes and challenges
- Providing landlords with clear lines of communication, support and emergency contacts when issues arise; these are offered through both the housing and service teams
- Offering ongoing education to landlords to help address stigma and discrimination around our participant population
- Working with landlords around eviction prevention and finding solutions that work for both the landlord and participants
- Use of rent supplements and help with property damages when they occur
- Moving our participants out of buildings into other accommodations

Early themes emerging from the data on At Home/Chez Soi that is present across all conditions:

- Understanding the meaning of choice over housing and treatment options
 - It is important to include options such as scatter-site apartments but also shared or congregate housing as some participants were worried about isolation
- The separation of housing and support aspects, as many participants have required “re-housing” and the supports need to remain consistent and available
- There are challenges in providing the broad range of support [i.e., geographical coverage, after-hours support, frequency of support visits]
- Recovery-oriented care presents challenges to teams as it does require a paradigm shift
- The importance of a housing procurement strategy

(Mental Health Commission of Canada, 2012)

An earlier study of the Mental Health Commission of Canada included a mapping process that confirmed that aging and deteriorated housing stock is a problem in many provinces. Many housing providers, who are leaders in innovative housing and supports, said that it was a constant struggle to find the funds for maintenance and upkeep. The mapping process showed that while options in securing capital funding for housing stock development exist, there are few opportunities to secure new, annualized funding to support tenants, subsidize rental costs, and sustain operational costs directly to landlords without adequate consideration for the living conditions. This problem is exponentially worse for the Aboriginal population (Mental Health Commission of Canada, 2010; Canadian Population Health Initiative, 2008).

As well, the persons currently in supported housing are getting older and their needs are changing, requiring a review of the resources attached to some housing that is not currently capable of handling the changes in their health and capabilities. (National Homeless Federation, 2011) (Ontario Supportive Housing and Diversity Group, 2008)

The Canadian Population Health Initiative (CPHI), a part of the Canadian Institute for Health Information, has been supporting research with the overall objective of “Improving the Health of Canadians”. The CPHI collaborated with the Homelessness Partnering Strategy to help build

partnerships and structures to assist homeless individuals and families move towards self-sufficiency through a housing first approach (Canadian Population Health Initiative, 2008).

Another national resource is Raising the Roof, “which provides strong and effective national leadership on long-term solutions to homelessness through partnership and collaboration with diverse stakeholders, investment in local communities, and public education” (<http://www.raisingtheroof.org>).

British Columbia

The Social Planning and Research Council of B.C. looked at service delivery to homeless persons with concurrent disorders within Canada with the objective of identifying or guiding provincial planning towards innovative approaches that were demonstrating positive outcomes. (For details on case studies, see Concurrent Disorders section of this review.) In this paper (Serge et al., 2006), the reviewers noted that many of the new approaches developed out of a recognition that mental health and substance use services were not integrated, resulting in marginalization and/or limited outcomes with people with concurrent disorders and a consequent overuse of acute care services. Key factors for success in most of the programs that were considered important to embed in any new initiatives included:

- Staffing availability, vigilance and knowledge about mental health and addictions
- Large and diverse inventory of affordable housing that is safe and private
- Protocols and support to address conflicts among tenants and between tenants and landlords
- No limits on length of stay
- Strategies to address evictions to prevent a return to homelessness
- The importance of employment

Vancouver

Vancouver Coastal Health Supported Housing Framework [2006]

- This framework was designed to address the needs of individuals with health conditions such as mental illness and/or addictions. It emphasized the development of:
 - Affordable housing for individuals who can live independently
 - Affordable, supported low barrier housing for individuals who are homeless and who are not yet ready to engage in mental health and/or addiction treatment services as a requirement to access housing
 - Affordable, supported transitional and permanent housing for individuals actively engaged in recovery-focussed mental health and addictions treatment
- The Framework assumed that new development in the affordable housing market would be in the form of purpose designed stand alone sites or rent supplements in existing private market rentals

The Portland Hotel Society

- This is an organization in Vancouver created by the Downtown Eastside Residents Association. The Association converted a local hotel and named it the Portland Hotel after the U.S. city on whose housing programs the new facility was modeled.

- The Portland Hotel provides permanent accommodation for 86 adults with problems that have led to homelessness. The program combines housing with supports as directed by the residents. (See Appendix B for details)

Alberta

In Alberta, the majority of the housing mandate falls under Alberta Human Services [for homelessness] and Alberta Municipal Affairs and the support services for Albertans are shared between many ministries including, but not limited to, Alberta Health and Wellness, Alberta Human Services, Alberta Justice and Attorney General and Alberta Seniors. Some of the key community-based service delivery agencies that provide housing and related supports are the Community-based Organizations related to homelessness projects, Management-Body Corporations and Alberta Health Services.

Alberta communities identified a number of barriers in plans to end homelessness including; high cost of living, significant numbers of people migrating to Alberta from the rest of Canada and other countries, a shortage of affordable housing, societal attitudes, a lack of coordination in mainstream systems and regulatory complexity and inefficiency.

In 2008 the Government of Alberta announced the establishment of the Alberta Secretariat for Action on Homelessness. The Secretariat was given a mandate to develop a 10-year provincial strategic plan outlining “a comprehensive, coordinated and sustainable approach” to ending homelessness – including goals, timelines and financial requirements.

Under Alberta’s 10-year plan to end homelessness by 2019, funding is being provided to community-based organizations in the seven major cities, which work with community partners to deliver services necessary to meet the unique needs of the homeless. Funding is allocated based on factors such as population and shelter space usage in the community. Housing First was a key approach in this plan.

Funding is used for supports such as intensive medical, psychiatric and case management services to help people resolve the underlying causes of their homelessness. These services are key to ending homelessness, because they help those who are now housed to stay housed and keep on track to independence.

The plan has five priority areas for action: robust information on outcomes, aggressive assistance, coordinated systems, increased housing options and effective policies. (Alberta Secretariat for Action on Homelessness, 2008)

As of March 2011, 3, 995 Albertans experiencing homelessness were provided with permanent housing and supports; 727 people had successfully transitioned from housing first intensive supports to a higher level of self-sufficiency in the community, 82 percent of individuals have remained housed and the number of people utilizing emergency and transitional shelters had declined by almost 6 percent. (Alberta Secretariat for Action on Homelessness, 2011)

Edmonton

A report by the Edmonton Homeless Commission identified barriers to success (KPMG and OrgCode Consulting, 2011). They include:

- Housing supply and support capacity to serve the homeless with intensive needs is limited within all sectors examined
- Individuals discharged from the justice system had to reapply for financial support after release, delaying access to housing
- Coordination of services and sectors is not sufficient; the capital and operating expenses for new housing is disconnected from funding for the kinds of intense and complex services required
- The Housing First programs existing in Edmonton were not designed to include the supports and expertise needed for the homeless with intense needs to be successful in maintaining their housing
- A continuum of supports that includes a range of options is needed

The report did identify some promising practices in Edmonton:

- Urban Manor: a 75 bed facility with 24 hour staffing that uses harm reduction principles
- Grand Manor, operated by Excel Society, a 56 unit apartment-style facility with 24/7 supports, primarily for individuals with dual diagnoses
- George Spady Center, which offers a variety of services for the homeless, including some crisis, detox and referral services
- PACT; the integrated mental health and police mobile teams

The report emphasized that permanent supported housing is a leading practice in preventing and ending homelessness and in addressing the needs of individuals with complex problems

Calgary

Calgary has implemented a Housing First approach as a cornerstone of its 10 Year Plan to End Homelessness. The reports from funded agencies and data from the Homeless Management Information System indicated that the total number of people housed since January 2008 would be about 4,000 by March 2012 and that about 30% of those clients were chronically or episodically homeless. A sample group had 92% housing retention rate after 12 months of intervention. There was an increase in treated mental health conditions of 28% in the last 12 months. Emergency visits and days in jail decreased by 50% (Calgary Homeless Foundation, 2012).

Since 2007, Calgary's Pathways to Housing Program has successfully used Assertive Community Treatment (ACT) with homeless people originally considered difficult to house (The Alex Pathways to Housing Project, 2009). In its 2009 study, since admission program results have shown that clients experienced:

- a 79% reduction in psychiatric hospitalizations
- a 62% reduction in police services contacts
- a 68% reduction in Emergency Medical Services (EMS) transports
- a 63% reduction in emergency room usage
- a 53% reduction in substance use in patients with concurrent disorders
- a 41% achievement or partial remission in substance use in patients with concurrent disorders

Ontario

Ontario Open Minds, Healthy Minds Mental Health and Addictions Strategy

- The provincial strategy paper pointed to coordinated access models to manage access to all mental health and addictions supported housing units through a common application form. Consumers then only have to apply once to be considered for all available housing and there is a single waitlist. As well, case management provider teams will use a coordinated access model (Government of Ontario, 2011).

Toronto

- Streets to Homes, a variant of Housing First, was initiated in 2005 as a strategy for ending street homelessness.
- Streets to Homes uses intensive case management (ICM) rather than assertive case management (ACT) and targets any person who is living “on the street”. It assists homeless people in finding housing directly from the streets. Abstinence from drugs or alcohol is not a prerequisite nor is compliance with medication. Participants do not have to be “housing ready” Different components of the program address employment issues, post-incarceration, addiction and mental health. As well, the Ontario Disability Support Program processes applications by Streets to Homes clients very rapidly (Falvo N. , 2009).
- An evaluation of the Streets to Homes Program in Toronto and its intensive case management approach found that over 80% of clients housed reported being positive about their future, experienced higher self-esteem, started to set goals, looked for volunteer positions and began to plan their return to school or work and almost 90% of program participants remained housed. Clients also reported better use of health and medical practitioners (Dolan & Hughes, 2011).
- There have been some shortcomings identified:
 - Unlike NYC Pathways to Housing, there is no stipulation that participants pay no more than 30% of their income on rent and this has led to some affordability issues.
 - Many participants did not report having a choice in the type of housing that they were offered.
 - The program does rely on shared accommodation for a substantial percentage of its units
 - There are some questions of replicability in other jurisdictions [market dynamics, model fidelity] (Falvo N. , 2009)
- Regent Park Social Development Plan
 - Regent Park was built 50 years ago as a low-income community cut off from surrounding neighbourhoods, which led to local barriers that undermined access to employment, education and other opportunities. The redevelopment is an example of reconstruction that accounts for improving social conditions. This is a resident-driven plan that provides a guide to creating a cohesive and inclusive community (Toronto Community Housing, 2007).

HOUSING ACROSS THE LIFE SPAN

Youth in Transition to Adulthood

Over the last 20 years, as housing and integrated support services developed across the world, the arbitrary stratification of these services by age evolved from historical precedent. Youth

transitioning to adult services often encounter barriers and the services are very different, built on different assumptions. For example, services for youth are usually more comprehensive, such as “wrap-around” services, while adult services generally expect the clients to advocate for themselves. Many young adults are lost in the first stages of this transition.

Youth transitioning into adulthood are expected to be “ready” for adulthood. However, designated ages for exiting care are not correlated with a young person’s abilities or readiness to be independent. Due to instability in the parental home and multiple placements throughout their time in care, youth often take longer to reach milestones of independence compared to their peers. For example, several studies found that youth in care are more likely to repeat grades. In Washington, youth in care in elementary or secondary schools were found to be twice as likely as their peers to have repeated a grade.

Youth aging out of care are left to worry about securing decent and affordable housing, having enough income, and finishing their education. This has led to disproportionately negative outcomes for youth in care as compared to the rest of the population. Some studies of this issue are recommending that “wraparound” services continue to age 25 for those transitioning youth, although only a few have considered housing as one of the solutions (Ontario Provincial Advocate for Children & Youth, 2012).

Aging Population – Health and Accessibility Barriers

People in supported housing who are aging do not have access to health services and housing designs that accommodate aging in place. At a vulnerable time in their lives, they can find themselves unable to live in the housing that has been so helpful to them and the support services are inadequate to meet their changing needs.

While substance use and mental health remain major medical issues for the homeless, the aging trends that have been observed suggest that chronic health conditions will take on increasing prominence for homeless health services as the population ages. A recent study reported that 85% of homeless persons over age 50 reported at least 1 chronic medical condition. Homeless health care providers will increasingly need to grapple with how to manage their complex chronic conditions. New programs that integrate health care with more stable housing may be important steps for avoiding end-stage disease and institutionalization in older homeless persons with complex medical regimens needing frequent office visits (Hahn, 2006).

Health concerns consisted of arthritis, seizure disorders, breathing problems, tuberculosis and cardio-vascular diseases, conditions commonly associated with advanced age, are appearing in people decades earlier than expected. Physical illnesses, injuries and disabilities were often caused and further aggravated by homelessness while disrespectful treatment by healthcare professionals has been found responsible for seeking care late and only for serious illness. Other diseases prevalent in this group are diabetes, hepatitis and HIV/AIDS. Housing facilitates receiving regular healthcare, including treatments for addictions. It prevents health problems resulting from exposure to the elements and contracting communicable diseases in overcrowded shelter. After being discharged from hospital or other facility, permanent housing allows for homecare and rehabilitation services after, thereby preventing or mitigating long-term disabilities. Being able to ‘lock the door’ reduces fears, prevents violence, and gives people back their dignity (Daiski, 2007).

The Healthy Aging Research Network, part of the U.S. Center for Disease Control and Prevention, [CDC-HAN] has made “identifying interventions that promote health aging and translating these into building sustainable community-based programs” part of their key research agenda [<http://www.prc-han.org/>].

Physical health issues often occur earlier and in more severe ways with people in supported housing, partially due to histories of homelessness and/or lack of access to good medical care in the past. Some innovative practices have begun to emerge. A mental health housing and case management organization in London, Ontario called WOTCH made a commitment to the physical health of its clients. They re-organized staff; hired nurses to fill some case management positions; introduced a foot clinic and diabetes screening; and taught other case managers about nutrition, diabetes, and other health matters. WOTCH also made a concerted effort to match its clients with family doctors.

The result is that WOTCH has observed increased foot care and client mobility, and increased use of local diabetes services. They have also seen markedly improved access to primary care. In 2006, 72% of clients had a doctor, 26% no doctor, and 2% no doctor by choice. By 2009, 96% had a doctor, 2% no doctor, 2% no doctor by choice. As well, Toronto housing agencies are looking at the Integrated Collaborative Case Management Protocol [Brooklyn, NY]. This initiative makes primary health care a key service goal and trains its supportive housing staff in the adverse effects of medications and in monitoring basic health protocols (Connelly, 2011).

Solutions to Accessibility Barriers

A proactive approach to the design of housing and communities that accounts for changing abilities in persons as they transition through their lives is Universal Design.

Universal Design is a framework for the design of places, things, information, communication and policy to be usable by the widest range of people operating in the widest range of situations without special or separate design. Most simply, Universal Design is human-centered design of everything with everyone in mind.

Universal Design is also called Inclusive Design, Design-for-All and Lifespan Design. It is not a design style but an orientation to any design process that starts with a responsibility to the experience of the user. It has a parallel in the green design movement that also offers a framework for design problem solving based on the core value of environmental responsibility. Universal Design and green design are comfortably two sides of the same coin but at different evolutionary stages. Green design focuses on environmental sustainability, Universal Design on social sustainability.

Design is only one part of the solution to a more inclusive world in which all people have equal opportunity for independence, autonomy and participation. But design matters. Universal Design is a framework that accepts diversity of ability and age as the most ordinary reality of being human and evaluates strategies and solutions based on how well they meet the needs of the widest possible group of potential users and enhance everyone's experience. It demands a quality of creativity and invention that can energize generations of designers to become partners with users in a revitalized appreciation of design as intrinsic to social sustainability (Institute for Human Centered Design, 2011).

To meet the needs of the growing aging population, it is important to establish policies that will increase the percentage of the existing housing stock that has universal design features and educate clients and builders about the importance of these features. Local communities might elect to target a specific percentage of their housing stock as universally designed and require new developments to incorporate the targets into their plans (Center for Disease Control and Prevention, 2010).

“The lack of accessible housing provides an opportunity for homebuilders to develop and market products that meet the needs of an aging population. In light of concerns about the civil rights of people with disabilities and the high public cost of nursing home care, housing accessibility is a critical issue for planners and policymakers as well. We believe planners should broaden their vision of the built environment to include the accessibility of the housing stock” (Smith et al., 2008). Some proponents suggest that if funding agencies begin to provide incentives to developers to use Universal Design principles, it could become more commonplace, in a similar way that ‘green building’ has evolved.

KEY POPULATIONS

Forensic services and incarcerated persons

The association between homelessness and imprisonment is bidirectional: imprisonment may precipitate homelessness by disrupting family and community contacts and by decreasing employment and housing prospects. Homelessness may increase the risk for imprisonment through shared risk factors and through increased likelihood of arrest (Metraux, 2007).

Exiting prisoners face important challenges to successfully reestablishing community life, including difficulties with securing housing and employment. They also have difficulty obtaining medical, mental health, and substance abuse treatment after their release (Kushel, 2005).

In a 2004 report in the U.S. (Black & Cho, 2004), persons in and exiting incarceration experienced significant disadvantages:

- 65% of prison inmates had not completed high school
- Over one-third of all inmates reported having some physical or mental disability
- 20-26% of all HIV/AIDS cases were releases from correctional facilities; releases with hepatitis C accounted for 29-32% of all cases and those with TB for 38% of all cases
- 70-85% of prisoners were in need of drug treatment but only 13% receive it while incarcerated

A number of studies have explored common profiles of homeless people who have been caught up in the criminal justice system:

- Homeless persons are less likely to be charged with violent offences, and more likely to be charged with property-related offences, such as those which meet their survival needs
- They are frequently charged with violations of municipal by-laws, such as loitering, noise, and panhandling. Crimes of the homeless are also more visible because of their

limited access to private places and may more easily attract police attention.

- Several risk factors have been associated with involvement in criminal offending including the length of time individuals are homeless and their exposure to criminal activity, peer pressure, as well as substance abuse and mental illness (Roebuck, 2008).

The above problems can be amplified when a person with a psychiatric diagnosis is institutionalized in a forensic psychiatry facility. Failures of a discharged forensic patient or a recently released prisoner in transition to the community may well be the product of a system failure. Being too briskly exposed to new demands in new settings, and denied access, overnight, to the security and familiarity of the preceding environment will invite failure. As well, many forensic patients and the incarcerated mentally ill are severely disturbed with multiple and grave diagnoses and a history of offending and, as a consequence, their families are burned out and disillusioned (Vincent, 2011).

Certain sub-groups are disproportionately vulnerable to post-incarceration homelessness, such as people with a diagnosis of Fetal Alcohol Spectrum Disorder, poor literacy, severe mental illness, trauma-related brain injury, low intelligence, and those with a prior criminal record, addictions, or heavy drug use. Additional groups are Aboriginals, racialized groups (i.e., black males from the Caribbean and North Africa), refugees, women (particularly those involved in the sex trade), youth who have been in foster care, and transgender persons whose gender issues are often misunderstood or ignored.

Lengthy periods of incarceration in remote locations often attenuate the social and family ties that are crucial for successful reentry into the community. Regained economic and residential stability almost always requires that a person receive, upon release from prison, support from family, social service agencies, faith-based organizations, or other parties interested in facilitating a smooth transition for the released individual. In the absence of such supports (and in some instances the absence of any type of effective discharge plan), individuals released from prison are at high risk for homelessness as well as other undesirable outcomes and the research indicates that homelessness is primarily a “re-entry issue” as homelessness is most likely to occur within 30 days of a prison release (Metraux, 2007).

Former prisoners are among the heaviest users of shelter services and are generally in the shelter system for more than six months. They have a 30 percent chance of spending more than one year in a shelter. Homeless and prison populations have high rates of communicable diseases because of poor health, unsafe sexual practices, illicit drug use, and close living quarters.

Homelessness is linked with rates of offending and victimization; those without shelter are more likely to be victimized, and more likely to engage in survival crimes. Providing housing, and social and income supports to end homelessness are the best approaches for addressing crime and victimization associated with homelessness. Large-scale initiatives of this nature require the cooperation and resources of all orders of government (Roebuck, 2008).

Alternatives to incarceration for homeless people with mental illness are possible. Culhane et al. (2001) found that homeless people with severe mental illness placed in supported housing experienced marked reductions in shelter use, incarceration, hospitalizations, and length of stay per hospitalization. Another study estimated that 95 percent of costs of supported housing with

this population were recovered by collateral service reductions attributable to housing placement (Roebuck, 2008).

Not Criminally Responsible (NCR) Patients

Most housing initiatives have not been established specifically to consider the needs of those who have been diverted from imprisonment because of their mental illness. For example, Seven Oaks is an initiative in Victoria, B.C. that consists of five resident houses plus a rehabilitation and administration building. The residents are in recovery from a long-term psychiatric illness and Seven Oaks accepts patients deemed as Not Criminally Responsible (NCR). There is a mixed population in the housing. (B.C. Provincial Health Services Authority, 2005) (Lesage, Groden, Goldner, Gelin, & Arnold, 2008) Housing initiatives focused on this population are not well represented in the literature.

There are a few innovative programs in Canada that are leading the way for developing housing and supports that are designed for the NCR population.

Toronto

The program, led by the Centre for Addiction and Mental Health (CAMH) attempts to reintegrate forensic patients into the community while managing the risk that these individuals present to public safety. This goal is met through psychiatric treatment, case management and the treatment of criminogenic risk factors. Currently there are two contracted housing units managed by the Canadian Mental Health Association (CMHA). In the early stages of this program, CMHA and CAMH identified key issues that needed formal agreement:

- Selection of patients needed to conform to Assertive Community Treatment clinical criteria
- Risk management
- Who was responsible for the patients in the community
- Emergency hospital admissions
- The role of psychiatrists

(Canadian Mental Health Association, Toronto Branch, 2002)

Calgary

The Calgary Community Rehabilitation Program will be the first appropriately structured, supervised and supported residential living program in Calgary for individuals deemed either Not Criminally Responsible (NCR) or Unfit to stand trial due to a mental disorder. The program will provide care using a client-focused service delivery model based on six principles: choice, dignity, privacy of person and space, independence, individuality and the creation of a home like environment that operates within the boundaries of the individual's disposition orders and public safety.

This will be a six-bed residential rehabilitation home in Calgary for NCR/Unfit patients currently being cared for in Alberta Hospital Edmonton who have been granted privileges by the Alberta Provincial Review Board to reside in the community in supervised accommodation. The specialized program of psychosocial rehabilitation treatment will support continued development of patients' independent living skills as well as provide a safe community environment for patient assessed for readiness for less supervised accommodations.

Forensic Psychiatry patients would be eligible for residency in the program if they have had a risk assessment completed and were approved for community living, cannot be accommodated in another community placement as they require clinical support, are deemed by the current treatment team to be able to function in a group living setting and do not display aggressive or abusive behavior that cannot be managed in a group setting.

The Calgary Community Rehabilitation Program will serve individuals who require 24 hour on site care. On-site staff will include a house coordinator and 24/7 professional nursing support. In addition, regular on-site support will be provided by a clinical team consisting of a psychiatrist, social worker, psychologist, recreation therapist and Occupational Therapist. Spiritual services shall be provided by the program Chaplain. 24/7 security personnel will be on site and a key card access system will be utilized to ensure the safety of the clients as well as the surrounding community.

(Alberta Health Services, 2011)

[Housing Options post-incarceration](#)

Transitional Housing

New York City's Castle Gardens and the Fortune Academy, operated by the Fortune Society

- Mixed use affordable housing; 50 studio apartments providing supportive housing for homeless individuals with histories of incarceration and 13 one-, two- or three-bedroom apartments providing supportive housing for homeless families with at least one member who is formerly incarcerated
- A service center is adjacent to the property with diverse, culturally competent, re-entry supports available
- Lengths of residency are indeterminate and contingent upon individual needs
- All residents are expected to move into private, unsubsidized housing at the end of their stays (Black & Cho, 2004; McDonald et al., 2008).

St. Leonard's Ministries' St. Andrew's Court provides 42 units of "second-stage" supportive housing to homeless men with incarceration records. St. Andrew's Court is described as "second-stage" permanent housing because it serves individuals leaving St. Leonard's Ministries' transitional housing facilities. By contrast, the Bridge, Inc.'s Iyana House serves women with mental illness immediately upon their discharge from state prison. Tenants are engaged by the provider toward the end of their prison sentence and are recruited to live at Iyana House, in some cases transferred directly by the parole agency to the housing site (Metraux, 2007).

Central City Concern's Housing Rapid Response program in Portland, Oregon, targets frequent users of multiple public systems. These persons not only present the greatest levels of need, but also are also among the most costly, in terms of services consumption, subsets of persons in the nexus of homelessness and incarceration. Since program inception in 2005, nearly 300 people have secured a more stable life, resulting in reduced arrests, a 62% increase in employment or benefits and an 85% increased enrollment in recovery programs.

Permanent Supported Housing

The FUSE [Frequent Users System Engagement – sponsored by the Corporation for Supportive

Housing] model includes targeted Housing and Services: Supportive housing—permanent housing linked to individualized supportive services—is enhanced with targeted and assertive recruitment through in-reach into jails, shelters, hospitals and other settings, in order to help clients obtain housing stability and avoid returns to costly crisis services and institutions. The steps involved include:

- Design and Assemble Resources for Supportive Housing and Assertive Recruitment through In-Reach into Jails, Shelters and Other Services Work with partners to design the intervention—supportive housing coupled with assertive client engagement and recruitment through in-reach into jails, shelters, and other settings—assemble the resources needed for the intervention (i.e. rent subsidies, unit set-asides, services funding), and select participating providers.
- Recruit and Place Clients into Housing and Stabilize with Services Work with and train selected supportive housing providers to proactively recruit frequent user clients from the data-generated list by conducting in-reach into jails, shelters, and other crisis service settings. Providers engage and build motivation among clients and place them into supportive housing rapidly. Once placed, clients are assisted in developing and meeting service goals to increase housing stability and prevent returns to jails, shelters, and other services.
- Troubleshoot Barriers to Facilitate Housing Placement and Retention Through routine oversight meetings, the working group reviews and troubleshoots barriers to housing placement and retention, especially barriers that stem from bureaucratic approval processes.
- Track Recruitments, Placements and Avoidance of Crisis Services Systems and procedures are created to conduct real-time tracking of client recruitment, housing placement, and client use/avoidance of jail, shelter, and other services.
- Measure Reductions in Crisis Services and Cost-Effectiveness of Model Outcomes and impact are measured either through a formal evaluation or informal outcomes tracking process, which measures reductions in jail, shelter and other crisis services used and attendant cost offsets. These cost offsets are compared against the cost of supportive housing.

Outcomes for Supported Housing Programs Post-Incarceration

Maryland's Shelter Plus Care program, operating in 21 counties, provides tenant and sponsor-based rental assistance to persons with serious mental illness coming from jails. Case management and supported services are provided. Outcomes tracked by the State of Maryland demonstrate that recidivism to jails is less than 7 percent. Only 1 percent entered hospitals and only 1 percent were homeless during the evaluation period (SAMHSA, 2003).

Returning Home Initiative [sponsored by the Corporation for Supportive Housing in the U.S.], emerging evidence:

- Seattle:
 - 45% reduction in jail bookings and 42% reduction in the number of jail days
- Denver:
 - Study of 100 chronically homeless individuals; supportive housing led to a 76% reduction in number of days spent in jail.

- Los Angeles:
 - 95% reduction in costs to county jail for people in supportive housing compared to similar individuals who were still homeless and a 67% savings for mental health jail services

The FUSE program is showing real promise as part of the Returning Home Initiative:

- Hennepin County:
 - 39% reduction in the number of days in county jail for participants in the Hennepin County FUSE program.
 - 43% reduction in the number of nights spent in shelter by participants in Hennepin County over the course of 22 months.
- New York:
 - A 50% reduction in the number of days in jail for participants in the New York FUSE program, compared to a comparison group.
 - Preliminary findings from New York show that after 12 months, only 16% of the program group had any shelter admission compared to 98% of the comparison group.
 - Preliminary findings from New York show lower rates of alcohol and drug abuse—specifically injection drug use—among people in the program. In addition, the proportion of people with earnings and/or entitlements is much higher for people in the program.

(Corporation for Supportive Housing, 2011)

Many supported housing interventions are modified or enhanced versions of interventions traditionally designed to serve other similar target populations such as homeless individuals or persons with serious mental illness (Black & Cho, 2004). For example, Burlington, Vermont's Dismas House is a modified version of the successful Oxford House model, adapted to the specific needs of persons leaving incarceration (Hals, 2003).

Forensic assertive community treatment (FACT) is an adaptation of the assertive community treatment model designed to prevent criminal recidivism through criminal justice collaborations (Lamberti et al., 2011). A FACT program in Atlanta has shown substantial reductions in both criminal justice involvement and homelessness among its caseload of persons diagnosed with mental illness. New Jersey's Program to Return Offenders with Mental Illness Safely and Effectively (PROMISE) Initiative has demonstrated the effectiveness of FACT at reducing recidivism in its combination of supported housing and ACT-like intensive case management to parolees with mental illness who are found to be homeless at the time of their release (Lamberti et al., 2004).

This case management is often supplemented with services from specialized personnel such as community supervision officers (as in FACT teams) or certified substance abuse counselors. Similarly, many housing projects targeted towards persons with histories of both homelessness and incarceration tend to use higher service worker-to-client staffing ratios (Hals, 2003).

"Promising programs tend to integrate services and treatment with either permanent or transitional housing rather than offer either services (i.e., case management) or affordable

housing alone” (Metraux, 2007).

Key learnings

Were the criminal justice system to extend its mandate and work in coordination with the community supports services and housing, the end of involvement in the criminal justice system would not be marked by the completion of a sentence of incarceration, but by a reintegration into the community. The latter part of a person’s sentence could be used for this, or the community housing and support services could extend beyond the sentence. This would extend reentry services and roll back the need for homeless services.

In 2012, the Corporation for Supportive Housing has recommended that the U.S. Congress reauthorize the Second Chance Act with an increased emphasis on coordinating housing and services [<http://www.csh.org/csh-solutions/policy-and-advocacy/federal-policy-priorities>].

A consistent finding in reviewing literature on post-incarceration successes, is the centrality of housing, coupled with supports in mitigating effects of homelessness and incarceration (Metraux, 2007).

Substance Use

The literature is divided on the effectiveness of abstinence-based and harm reduction approaches for persons with substance use [without co-occurring mental illness].

Small differences between groups where abstinence was a criterion for housing versus harm reduction housing which did not require abstinence prior to receiving housing suggests that there is very little difference in outcome in these approaches – both are successful (Milby et al., 2005). It is clear that both abstinence-based and harm reduction approaches can achieve success. In developing new programs, it is widely recommended that policy makers move away from an either/or approach and acknowledge that both abstinence and harm reduction initiatives can meet the needs of different clients (Serge et al., 2006).

For individuals with severe and active addiction, the evidence is sufficiently mixed and incomplete to recommend caution in generalizing results. Some of the reasons include:

- The quality of addiction treatment is undermined by widespread discrepancies between the principles of effective treatment and what most clients typically receive
- In one study comparing harm reduction and abstinence required, clients who were required to maintain abstinence began abandoning the provided housing, complaining that their proximity to persons not required to remain abstinent was detrimental to their recovery. They claimed that they preferred to return to homelessness rather than live near drug users (Kertesz, 2009).

Despite evidence that housing is a crucial component in the recovery process, many substance use strategic plans do not make recommendations regarding housing. For example, the Nova Scotia Best Practices document identifies that “a flexible housing arrangement based on a harm reduction orientation (that is, accepting some level of substance use) is commonly recommended as an important ingredient in promoting the health of individuals” with substance abuse problems. However, no specific recommendation or guideline is made (Nova

Scotia Department of Health Promotion and Protection, 2008).

One of the most comprehensive studies on a support and housing model for homeless persons with substance abuse was an initiative called the NY/NY III project.

This was a study of the application of the Housing First and low demand models to a group of homeless persons identified as “Population E”, which were persons experiencing homelessness but who did not have a serious mental illness. The project did attempt to achieve some degree of model fidelity. Through a process of collaborative inquiry with program directors and other staff, a Theory of Change was constructed and helped guide the following program activities:

- Recruitment, Tenant Selection, and Intake
- Housing Search, Provision, and Management
- Support Services

The Theory of Change also stipulates that this housing is two semi-distinct interventions—subsidized housing and support services—operating in parallel to influence two sets of outcomes—housing stability and health/ psychosocial outcomes.

Outcomes to date have been very positive. Details of this project can be found in Appendix B as a Best Practice.

(National Center on Addiction and Substance Abuse at Columbia University, 2012)

Downtown Emergency Service Center (DESC) 1811 Eastlake is a Housing First program developed in Seattle, Washington, which targets homeless adults with severe alcohol problems who are frequent users of local crisis services. (Detailed description in Appendix B) Residents at 1811 Eastlake have no treatment requirements, but on-site case managers work to engage residents about substance use and life goals. Meals and on-site health care services are also offered. Researchers from the University of Washington studied outcomes using the participants of Eastlake and compared them to persons on a waiting list for accommodation in the same program. The project demonstrated significant cost savings and reductions in alcohol use for housed individuals over the course of the first year. Cost offsets for Eastlake participants at 6 months, in comparison with wait-list controls and accounting for the cost of housing, averaged \$2,449 per person per month. At 12 months, the 95 housed individuals had reduced their total costs by more than \$4.0 million compared with the year prior to enrollment, or \$42,964 per person per year, as compared with a cost of \$13,440 per person per year to administer the housing program. Length of time in housing was significantly related to reductions in use and cost of services, with those housed for the longest period of time experiencing the greatest reductions.

The study also demonstrated that individuals in the housed group experienced reductions in their alcohol use and likelihood of drinking to intoxication over time, despite no requirement to abstain from or reduce drinking to remain housed (Larimer, 2009).

Concurrent Disorders (Mental Health and Substance Abuse)

Concern has been expressed that public mental health service systems are not versatile enough to meet the multiple needs of homeless individuals with concurrent disorders and have failed to engage most of this population in treatment (Serge et al., 2006).

The literature appears to indicate that homeless individuals with concurrent disorders do not accept an environment that is too restrictive or rigid, and heavily controlled residential treatment models in which housing and treatment are tightly bundled are associated with recruitment and retention problems. The literature generally recommends that programs be flexible and encourage people with concurrent disorders to enter gradually without requiring abstinence. The literature states that programs segregated from the community result in rapid relapse rates when clients are discharged and suddenly reintroduced in to the community. Residential programs are most likely to be successful when they are located within clients' natural communities, and when they provide opportunities for community reintegration (Serge et al., 2006).

Housing Provided in Case Studies: adapted from Serge et al. (2006)

Project	Type of housing	Type of unit	Type of provider	Scattered or Dedicated Site	Abstinence or Harm Reduction
Walking to Wellness, Nanaimo	Transitional and permanent	Shared and self-contained	Non-profit and private	Scattered and dedicated	Harm reduction
5616 Fraser Street Supported Housing Vancouver	Transitional supported housing	Self-contained	Non-profit	Dedicated	Harm reduction
Westview Dual Diagnosis Program, Regina	Transitional treatment facility (LOS is 3 to 5 years)	Self-contained	Non-profit leases building from private landlord	Dedicated	Abstinence is inclusion criteria but harm reduction applied during stay
Mainstay Residence, Winnipeg	Transitional	Shared	Non-profit	Dedicated	Abstinence
Housing and Supports, Peel, ON	Permanent	Self-contained	Non-profit and private	Dedicated and scattered	Harm reduction
Housing with Outreach, Mobile and Engagement Services (HOMES), Hamilton, ON	Permanent	Shared and self-contained	Non-profit and private	Dedicated and scattered	Harm reduction
HIV Project, Montreal	Permanent	Self-contained	Non-profit and public	Scattered	Harm reduction

The importance of housing must be recognized in any program that is created to address the needs of people with concurrent disorders. This includes housing where the residents feel safe and where the housing providers understand their tenants. It is clear that a range of options is necessary, including housing that is supportive, that incorporates a harm reduction approach and promotes stable tenancies for people with concurrent disorders, as well as housing that is alcohol and drug free.

The issue of transitional housing, especially in a context where suitable permanent housing is not available needs to be revisited and re-examined as a program and policy response. This issue was especially underlined in Winnipeg where there is a cycle of people getting support, getting better and then having the progress negated because neither long-term support nor suitable permanent housing is available. People also continued to live in Mainstay because there was nowhere else for them. However, this was not the only case – HASP was a response to a similar problem of people continuing to live in shelters because there were no alternatives for them (Serge et al., 2006).

One study focused on the client perspective to gain a deeper understanding of housing preferences. The clients all had concurrent disorders and lived either in independent supported housing or in supervised congregate housing. Findings were:

- Autonomy: clients in both supervised and apartment housing reported enjoying the amount of independence, ownership, and space their living situation provided
- Privacy; clients in supervised housing complained of a lack of privacy
- Community; only clients in the congregate supervised housing described a sense of community and peer support
- Barriers to housing; the only barrier to supervised housing was a waiting list; those in independent apartments generally encountered difficulties [i.e., legal history, stigma]
- It did not appear clients went through a thorough decision-making process when selecting housing. Sometimes clients moved simply to leave an undesirable living situation (i.e., homelessness, housing dissatisfaction), and other times they moved as part of their recovery.
- Clients moved from place to place based on what was available and where treatment providers suggested they go.
- Reasons for preferring supervised housing were structure, a substance-free environment, and staff and peer support.
- Reasons for preferring independent housing were privacy, autonomy, independence, and space.

This study confirmed that client preferences for housing change over time. While all clients stated that their future preferences were for independent living, many sought other types of housing [i.e., supervised] based on the stage of recovery. The findings support other study conclusions that an array of housing options is preferable (Tsai et al., 2010).

Largely unrecognized in the supported housing model is the import of informal supports and client empowerment. The overwhelming majority of clients – including those of racialised and ethnic minority background express a preference to live in their own ‘scattered site’ units and to

not live with others who also have mental illnesses or addictions issues. Among the advantages of scattered site housing is that, in not concentrating clients in one building, such forms of housing are better able to integrate clients into the community and much more easily due to the fact that the clients are not immediately identifiable.

Housing consumers in scattered sites also has the advantage of limiting the repercussions of substance abuse relapses, since only the individual is immediately impacted in his/her housing environment. Given the high incidence of isolation and stigma among racialised and ethnic minority clients, scattered site housing will likely be most suitable and favourable. The main potential problem faced by clients in scattered site housing is social isolation (Supportive Housing and Diversity Group, 2008).

A comprehensive B.C. study concluded that effective concurrent disorder programs combine mental health and substance abuse interventions that are tailored for the complex needs of this population. The critical components of effective programs include:

- a comprehensive, long-term, staged approach to recovery
- assertive out-reach; motivational interventions
- assistance in acquiring daily living and illness-management skills
- cultural sensitivity and competence

This study acknowledged that the literature is not conclusive in a number of areas for homeless persons with concurrent disorders but states that some clarity emerges. Housing with supports makes a difference over no housing, affordability is key, and there is some suggestion that housing with more well-defined services (i.e., ACT) may be even more effective than other forms of housing with supports. The effectiveness, and ultimately costs of homeless services can be improved by matching the type of service to the client's level of psychiatric impairment and substance use (Patterson et al., 2008).

Harm Reduction vs. Abstinence Programs

One longitudinal study contrasted a program that offered immediate permanent housing without requiring treatment compliance or abstinence and “treatment first” programs for homeless adults diagnosed with concurrent disorders. After 48 months, results showed no significant differences in alcohol and drug use, demonstrating that adults with concurrent disorders could remain stably housed without increasing their substance use regardless of whether they sought treatment for their substance abuse (Padgett, 2006).

One study review in Canada noted that residential programs (including jail/prison), hospital-based programs, and programs based in addictions agencies tend to require abstinence from clients while in treatment. Programs based in mental health agencies tend to be more harm-reduction (non-abstinence) focused. A slim majority of both American and Canadian agencies favoured non-abstinence philosophies over abstinence (Puddicombe et al., 2004).

Many persons with concurrent disorders who were in the process of recovery and had achieved sobriety stressed the importance of long-term drug-free housing and of staying away from familiar neighborhoods and people that trigger the desire to use drugs:

“At the shelter, I only had to stick my head out the door to use. It’s best to change where you

live, even if you can't keep it." "I just stayed away from the people that I used to get high with. I wouldn't go outside. I just stayed in the house." "Being here (in a residential treatment program) gives me a foundation. I was in a halfway house and I couldn't stay clean there" (Davis & O'Neill, 2005).

The model presumes that the skills a client needs for independent living can be learned in transitional congregate living. Research in psychiatric rehabilitation indicates, however, that the most effective place to teach a person the skills required for a particular environment is within that actual setting.

Paradoxically, clients' reluctance to use traditional mental health and substance abuse services as a condition of housing only confirms providers' perceptions that these individuals are "resistant" to treatment, not willing to be helped, and certainly not ready for housing.

In addition, contrary to the fears of many providers and policymakers, housing clients without requiring sobriety as a precondition did not increase the use of alcohol or drugs among the experimental group compared with the control group. Providing housing first may motivate clients to address their addictions to keep their housing, so that providing housing before treatment, may better initiate and sustain the recovery process.

Our findings indicate that ACT programs that combine a client-driven philosophy with integrated concurrent disorders treatment based on a harm-reduction approach positively affect residential stability and do not increase substance use or psychiatric symptoms (Tsemberis, 2004).

Mental Health and Persons with Developmental Disabilities (PDD) – Dual Diagnosis

In a 2006 study by CMHC (Canada Housing & Mortgage Corporation, 2006), stakeholders and clients were interviewed and a number of options or models were cited as best practices that embody the over-arching principle of flexibility and choice in housing for adults with intellectual disabilities [not necessarily with mental illness] They were:

Independent living model: An independent living model is one in which the person with an intellectual disability lives independently, often sharing a house or apartment with other clients and/or with service providers. Service providers may also be close by (for example in a neighbouring apartment) instead of sharing living quarters.

Example: The Annex Group: Community Living Toronto:

Note: All examples are from (Greenspan & Raine, 2006)

- A group of parents came together to rent a 2- bedroom apartment for two of their children to move in and develop their independent living skills as an interim step before moving to their own apartment. The intention was that after the first two individuals had moved out, another two would use the apartment to develop their skills. However, after the two initial residents reached a sufficient level of independence, they did not want to leave the apartment.
- The group of families decided to rent another unit in the same building to use for training the next two individuals. Again, these residents did not want to leave the apartment when their training phase was over, and another unit was rented in the same

building.

- Community Living Toronto assisted with workshops on independent living skills such as cooking and safety. The families continued to provide support to their children and many of the individuals continue to live in the building, although most have obtained their own one-bedroom apartment in the building.

Co-ops and co-op-like arrangements: In co-op housing, a group gets together, builds their own multi-unit building, and gives up some private space for community space. Residents are people who want not just housing, but also community support.

Examples: Robert Cook House, Etobicoke, ON

- 15 units, 21 residents: The parents of several individuals with developmental disabilities wanted to create a housing alternative for their children, and formed a charitable organization called Alternatives for Community Living Etobicoke (ACLE). They came together to construct a co-op, named in memory of a person with a developmental disability who was assaulted in the community and died.
- After the funding for the housing was approved, the families eventually received support funding from a partnership between several non-profit agencies, including Christian Horizons and Community Living Toronto who assumed the units within their legal framework.
- The families participate in activities with the residents and get additional funding from the City of Toronto to hire support staff for summer activities.

Prairie Housing Co-op, Winnipeg, MN

- The co-operative was developed through one individual's desire to leave an institutional setting. A group of his friends and family got together to come up with an independent housing arrangement and this led to the formation of the co-op, which now owns 19 suburban family homes and 28 units in a converted warehouse in the historic Western Saddlers building in Winnipeg.
- The co-op is comprised of several 'clusters' of houses wherein non-disabled neighbours and housemates provide volunteer support to residents with disabilities. Paid support workers provide additional support where needed. Cluster locations were chosen in neighbourhoods close to other family members and friends, and close to amenities, employment opportunities and community services.
- In each neighbourhood, the co-operative purchased clusters of several houses or apartment units. No more than two people with disabilities live in each home. The housing arrangement remains separate from the paid service support to ensure that the security of housing is not affected by the service relationship.

Equity co-ops: An equity co-op is an incorporated group of shareholders or members who jointly hold title to the land and buildings. Through the purchase of equity shares, the members are entitled to live in a unit. Co-op members have security of tenure similar to ownership in their own unit, but collectively own and manage the building. Costs are reduced through the pooling of resources and the non-profit nature of the development; therefore, government subsidies for capital are not required. When members leave the co-op, they may take their equity and some part of the appreciated value of their shares.

Example: Ottawa Share Equity Housing Project

- In response to a long waiting list for group homes, the Ottawa-Carleton Association for Persons with Developmental Disabilities (OCAPDD), developed an innovative financing model to allow parents to share in the cost of housing for their adult children who will receive quality service in a supported independent living environment.
- The partners developed a plan to purchase an 18 unit building with financial support from CMHC and the families of future residents. Through their financial contribution of an equity share in the co- op, the families would have guaranteed the right to lease a unit for their family member on a permanent basis.
- As the capital cost of the building is prepaid through the equity contributions, there is no ongoing mortgage expense, only ongoing operating costs. These operating costs were expected to be covered through the shelter allowance of the disability benefits received by residents, based on approximately 20 residents sharing a support worker.

Supported Independent Living: Usually a group home but with more involvement/responsibility expected from the clients. Services typically include one-on-one support with daily tasks, training in independent living skills and community involvement.

Example: Crosswind Apartments, Ottawa, ON

- The Crosswinds Apartment Program of the Ottawa-Carleton Association for Persons with Developmental Disabilities (OCAPDD) serves sixteen individuals in eight apartment settings with a mix of SIL and fully-supported units.
- Each person has his or her own bedroom in an apartment shared with one other individual. Three of the units are of 3-bedrooms, with six people living in them. Additional room in each of these units is for staff. The other ten people live in five two-bedroom units without permanent staff.
- Staff support is 24 hours a day, 7 days a week as in group homes but ratio is lower: staff to resident ratio is 1:4 people during the evening and 1:16 ratio overnight and during the day.
- Staff carry a cell phone with them for emergencies. All apartments have the cell phone number pre-programmed into their phones such that with the press of one button, residents can speak to a staff at any time.

Semi-supported Independent Living: These are apartments that are normally smaller than a typical group home with 4 client residents only. The house is less regimented, and much more homelike than a group home. Clients have greater control of their schedule, are more mobile, and determine their own activities. They usually attend day programs or have jobs. Clients do most of the household chores and are assisted in these activities. Staff support is provided in the morning and at suppertime, usually about 3 hours a day. Staff are available 24/7.

Example: L'Arche

- Founded by Jean Vanier in 1964, L'Arche is an international network of homes where people with developmental disabilities live together with others who feel motivated

to share their lives with them. The philosophy of L'Arche is to create environments where mutually enriching relationships between people with and without developmental disabilities can develop.

- On the surface, L'Arche communities look like traditional group homes; however, they provide a more family-like atmosphere as assistants live together with people with disabilities and share in daily tasks and leisure time. The focus of L'Arche is facilitating social inclusion by highlighting the gifts and abilities of each person, and the development of long-term relationships. Group members with disabilities are encouraged to make choices and decisions about the daily running of the home and community.
- Assistants are required to make an initial commitment of one year, with the first three months as a period of orientation. Assistants are paid a modest monthly salary and benefits, and have a limited amount of personal time each day, and days away each weekend month. Some L'Arche assistants have their own home and life, but participate in community events and maintain a close connection with the residents.

FASD

Fetal Alcohol Spectrum Disorder, caused by prenatal exposure to alcohol, is the leading cause of development and cognitive disabilities among Canadian children (Burns, March 2008). Studies do not agree on prevalence rates, but three ranges are published:

- Affecting an estimate of 1 to 6 in 1000 live births (Burns, 2008)
- 9 in 1000 live births (Public Health Agency of Canada, 2007)
- Higher rates suggested for prevalence in Aboriginal communities, some as high as 25 to 200 per 1,000 live births in some isolated northern communities (Masotti et al., 2003).

Having FASD is challenging as its effects can range from subtle (often considered as a hidden disability) to the more serious, which may include congenital abnormalities of the heart and other organs, brain abnormalities, behavioral and learning disorders, neuropsychiatric symptoms and mental retardation (Up North Training Services)

Clients affected by this 'continuum', with differing degrees of expression of dysfunction and malformation are also challenged with secondary disabilities: "those that a person is not born with, and that could presumably be ameliorated through better understanding and appropriate intervention" (Burns, 2009; Burns, 2008; Clark et al., 2004) suggested these secondary disabilities, with prevalence (Stade & Clark, 2004) to include:

- Mental health problems (90% all ages),
- Disrupted school experience (suspension, expulsion or dropping out – 60%, 12 years and older)
- Trouble with the law (60%, 12 years and older),
- Confinement (inpatient treatment for mental health or drug/alcohol problems or incarceration for a crime – 50%, 12 years and older)
- Inappropriate sexual behavior (50%, 12 years and older)
- Alcohol/drug problems (30%, 12 years and older)

- Problems with employment (80%, 21 years and older)
- Dependent living (80%, 21 years and older), and
- Problems with parenting

Dealing with these life-long symptoms, many of these individuals have problems accessing services. Services, recognized within current provincial bodies for adults with a disability, are not inclusive of adults with FASD, unless they fit the IQ criteria (Burns, 2008). (“The average IQ in FASD is between 75 and 85, with the full range in FASD between 20 and 140+. Almost all individuals with FASD have an AQ <70 (adaptive quotient, measure one’s ability to function day to day without supports in the areas of communication, socialization, daily living, time management, employment, etc.” (Burns, 2009)). Research further illustrates that 80% of adults with FASD are unable to live independently, regardless of their IQ (Burns, 2009).

Range of Housing Models

Housing tenure is jeopardized when clients with FASD act out with inappropriate behavior and poor life skills often resulting in eviction, further contributing to low employment prospects because of their need to continually move (Up North Training Services). The provision of housing alone would not provide the direction, supervision, mentoring, trusted relationships and other supports that many with FASD require (Burns, 2008).

The absence of suitable housing for youth transitioning into adulthood shifts the burden of care to the biological, adoptive or extended family. For those with families who do not have the ability to provide such support often find themselves in a correctional facility, short-lived stay with family or friends, or cycling in and out of homelessness.

Literature suggests that housing models are most effective when service delivery meets the needs of the individuals which has been shown to include an understanding of the disability, presence of strong community and stakeholder partnerships, removing barriers that exist before one is eligible for housing and having sustainable funding.

Assertive outreach and alternative options for housing have been recommended to assist those unaware of what programs and services are available to them, especially for those without family or support networks .

People with FASD have complex housing needs and a ‘one size fits all’ approach does not meet the needs for this population. Adaptable strategies, which can make accommodations, encourage client self-control and esteem, increase prevention in secondary disabilities are characteristics which should be considered as part of an effective program and are shown to be particularly effective when implemented before any conflicts/disputes arise (Burns, 2009).

In her report, Burns (2009) illustrated a housing model that British Columbia Housing, in partnership with community agencies working with homeless individuals, has found to be effective. As part of this model, outreach workers provide support to clients through a wide-range of activities including:

- Addressing immediate physical and safety needs: food, warm clothing, place to stay

- Connecting clients with housing and income support, including accompanying them to appointments
- Providing links to other appropriate supportive services: skills training, personal health, household and financial management
- Acting as a landlord liaison

Research shows that there are limited housing models across Canada that provide specific programming to individuals with FASD. Many models, developed and implemented to support individuals with PDD, also are including individuals with FASD. An overview of some such housing models is provided in Appendix B – Best and Promising Practices, some of which are without published outcomes as they are too new to have established a track-record (Burns, 2009).

Challenges Experienced by Client and Health Providers

Housing, in the absence of adaptable strategies, has been shown to result in the following challenges commonly experienced by client and health providers:

- 1) Housing Tenure – With frequency of evictions, housing is difficult to find and maintain – a constant struggle, aggravated by the use of drugs and/or alcohol (Up North Training Services)
- 2) Housing Options – Lack of options for caregivers of youth with FASD when planning for transitions from adolescence to adulthood
- 3) Treatment Programs – Treatment programs designed for the general population are not effective for those challenged with FASD – very few programs are specifically tailored for this group (Up North Training Services).
- 4) Sustainable Program Funding –
 - Many adults with FASD do not fit the profile of others benefiting from provincial programs (PDD) or those with genetic disability. They are often further challenged with secondary disabilities further adding to issues requiring supports (Burns, 2008).
 - In Alberta, when youth with FASD turn 18 years old, many of the resources they were originally provided with have terminated (Burns, 2009; Burns, 2008).
 - Adults with FASD, or those never given a confirmed diagnosis, often deal with systems lacking understanding of the disability, or services and supports able to assist with their needs are unavailable (Burns, 2009).
- 5) Employment – Maintaining focus can be difficult for this population, the lack of which contributes to unstable employment. Being responsible for their possessions, which have been obtained as a result of employment, has also been cited as a challenge (Up North Training Services).
- 6) Staffing and Retention (Burns, 2008 –
 - Difficult to find someone with specialized FASD training
 - Some have values-model contributing to their difficulty in transitioning between different models of care

- Staff burn-out, as a result of long hours, and challenges with developing training programs for new staff and providing on-going support to current staff (both affected by non-sustainable funding in the non-profit models)
- 7) Safety and Security - According to Burns (2008), the Yukon Territory Government-Health and Social Services found that when staff were on site clients were safer and experienced lower rates of victimization than when they were not.

Any adult with FASD, requires stabilization as the fundamental approach to improving their quality of life. This can only be attained if the family and agencies have the means of providing continuous support, along any part of the age/care continuum. Burns (March 2008) suggests that supported housing is the foundational piece required to decrease housing insecurity, along with justice, mental and physical health, relationship and financial issues.

Aboriginal persons

Aboriginal peoples in Canada are over-represented among the homeless population. Supported housing options that are geared toward Aboriginal peoples are very much needed and need to be investigated. In the academic and grey literature, there are no supported housing options that take into account Aboriginal peoples' unique cultural and mental health needs.

Aboriginal homeless services must be culturally appropriate and controlled by Aboriginal service providers in order to be effective. Ideally, Aboriginal supported housing would contain:

- A communal area (based on the long-house concept, for example) where tenants could practice their culture and rituals on-site
- Liaison workers who specialize in providing mental health and addictions treatment to this population
- Vocational rehabilitation workers who help tenants develop job skills while maintaining culturally-relevant skills
- Trades training could be linked to the construction of new housing units
- The Aboriginal perspective would address the health of the entire community, and how it affects the individual
- Elders could play a significant role in addressing the multi-faceted problems of homelessness even if they are not formally recognized by mainstream social service agencies
- Units could be stand-alone in urban and semi-urban centres, and integrated on-reserve.

Clearly, more research needs to be done on this option, and the Aboriginal community needs to be consulted and involved in the development and planning process. Housing and support geared towards Aboriginal peoples would help create a sense of spiritual and cultural belonging (Patterson et al., 2008).

Women and families

Because of the uniquely rapid rates of growth of both the body and brain in the earliest years, young children are immensely vulnerable to deprivation. Unfortunately, this deprivation is often invisible to all but their families and their healthcare providers.

How can housing problems lead to destructive deprivation?

First, it's critical to recognize that family homelessness represents the extreme end of a continuum of economically driven housing conditions that endanger young children. This range of conditions is termed "housing insecurity"—a concept analogous to the measurement of food insecurity.

"Housing insecurity," quantifies less visible forms of housing stress than homelessness. This consists of doubling up with other families for economic reasons, overcrowding, or moving two or more times in a year—conditions that put children at risk of negative impacts on their health.

Children in families who move this frequently are not only more likely to be food insecure but are 50 percent more likely to be in fair or poor health - as opposed to good or excellent health - and children in these families are 70 percent more likely to be at risk of developmental delays than similar children whose families do not move that often.

Housing insecurity can also impact child health even before children are born. Recent analyses show that women who experience homelessness during pregnancy are 50 percent more likely to have a low birth weight baby and over 30 percent more likely to have a pre-term delivery than similar women who were not homeless during pregnancy.

Housing policy can make a difference. Research has shown that housing subsidies will protect families from both housing insecurity and food insecurity. Similar to receiving one shot against multiple diseases, young children who live in subsidized housing are much more likely to be "well"—developmentally normal, not underweight or overweight, in good or excellent health, and with no history of hospitalizations (compared to those children who do not receive even this low level of support).

It is crucial to emphasize how protective subsidized housing can be for young children in the face of other kinds of deprivation. In the same way that some vaccines decrease the severity of an illness though they may not fully prevent it, housing subsidies double the chances that young children in families suffering from food insecurity will avoid stunted growth when compared to other young food insecure children whose families do not receive housing subsidies (Sandel & Frank, 2011).

Domestic Violence Housing First (DVHF) prioritizes the unique safety needs of domestic violence survivors and their children. While the Housing First approach is designed to bypass shelters and transitional housing programs, DVHF seeks to add to the support services and housing options available to survivors. Safety and self-determination are the driving factors, rather than the shortest possible timeline to permanent housing. The search for permanent housing does not usually occur until after the immediate crisis has been somewhat resolved.

DVHF does not replace domestic violence shelters. Domestic violence shelters provide critical, life-saving, emergency services. They are important for survivors and their children who need an immediate safe haven from an abuser. DVHF is intended as an additional option to provide a wider range of choices to meet the unique and varied needs of survivors. Also, DVHF strategies may be used to help survivors in emergency shelters access permanent housing (Tutty & Ogden, 2009).

Immigrants and Refugees

Three Categories of Immigrants (Citizen and Immigration Canada, 2010)

- 1) Family class immigrants – living with a close family member, who is already a resident of Canada, and who is assuming care and shelter responsibility until the immigrant is established in Canada
- 2) Independent immigrant – individuals with the special skills and experience transferable to the Canadian labour market. Not necessarily sponsored. This includes business immigrants: entrepreneurs, investors and the self-employed.
- 3) Refugee and refugee claimants – people who are seeking protection in Canada. Government sponsors some convention refugees; faith groups and other organizations privately sponsor others. Refugee claimants are those individuals in Canada who are seeking protection, but have yet to receive status.

Immigrants are not entitled to receive health benefits and as it may take months to receive work permits or student visas, many claimants live in poverty, overcrowded and unsafe housing, placing them at greatest risk of becoming homeless

Supporting Communities Partnership Initiative (SPCI) of the Government of Canada summarized their 2003 research into key themes related to immigrants and homelessness:

- 1) Socio-Economic Status
Immigrants and refugees are at-risk of homelessness because of poverty, reductions in social programs, unrecognized employment and education credentials, work permit delays, and mental illness.
- 2) Housing
Lack-of available, affordable housing stock and out of those that are available, many are inadequate for meeting the needs of immigrants or refugees
- 3) Shelters and Drop-Ins
Many immigrants and refugees experience shock when entering a shelter or drop-ins for a number of reasons: unsafe environment, lack of culturally-appropriate food, inability of specific needs being met: language training, legal assistance and claim forms
- 4) Discrimination
Discrimination among landlords, shelter and drop-in staff creates stress and create further barriers that prevent homeless immigrants and refugees from accessing housing and services.
- 5) Coordination of Services
Research found a lack of coordination between shelters / drop-in centres and settlement organizations, community, legal clinics and community health centres.
- 6) Training
Shelter staff requires training in current immigration and refugee policy, knowledge of culture, religion and history of immigrant and refugee groups.
(Murdie, Preston, Ghosh, & Chevalier, 2006)

CLIENT INVOLVEMENT

Clients as service providers in supported housing

Some unique characteristics of staff in recovery and those who have been homeless include: their knowledge of the service system; their “street smarts”; their ability to develop alternative approaches; their flexibility, creativity, and patience; their understanding of an individual’s basic needs and preferences; and their ability to build rapport with people who are homeless. Clients and recovering persons serve as positive role models, are a major force in the elimination of stigma and discrimination, and make good team members.

Programs run by clients and recovering persons—including drop-in centers, recovery support programs, case management programs, outreach programs, businesses, employment and housing programs, and crisis services—may be more “user-friendly” for people who are homeless or at risk of homelessness. The focus of service delivery in these organizations is on choice, dignity, and respect. Further, such programs provide meaningful work for clients and recovering persons. Staff in recovery from mental illnesses and substance use disorders, and those who have been homeless, also enhance the sensitivity of the system to the needs of their peers.

Programs must be prepared to support staff in recovery with adequate supervision and workplace accommodations, if necessary, and to educate and train other staff about employment for clients and recovering persons (Substance Abuse and Mental Health Services Administration [SAMHSA], 2003).

Effective Means of Involving Clients and Families

One researcher encouraged the involvement of clients in partnerships with researchers, mutually deciding both the goals and methods of research, to ensure that the products of research are directly relevant and are true to the concerns and experiences of clients. A final implication is for research that more effectively documents clients’ own values for their housing and their own lived experiences (Sylvestre, Nelson, & Sabloff, 2007).

NIMBY

The literature is unequivocal in concluding that residential programs are most likely to be successful when they are located within natural communities, and when they provide opportunities for community reintegration. The most significant barrier, besides an adequate inventory of community supported housing, is the anxiety-based forecasting of economic devaluation, increases in crime and other concerns that are part of NIMBY [Not In My Back Yard]. These fears are dramatically heightened when the proposed development is a residential facility for people with criminal records or other troubled and/or socially stigmatized individuals (i.e., recovering drug addicts, mentally ill individuals, people with HIV/AIDS – all of whom are represented in the population of people with criminal records). These fears typically escalated in accordance with the size of the facility and number of residents to be served, the seriousness of the potential residents’ criminal histories, and the likelihood that the facility’s neighbors would encounter the residents in public spaces and on public transportation. Levels of fear were elevated when the neighbors were unfamiliar with the organization proposing the program. An

additional exacerbating factor is when the community feels exploited by an unequal distribution of social service programs in their neighbourhood (Fortune Society, 2009).

Evidence: impact on property values

The research on the impact of locating supported housing, transitional housing and affordable housing in established neighbourhoods is very uniform in reporting that these units do not negatively impact surrounding homes.

A meta-analysis undertaken 20 years ago showed that the location of residential treatment facilities had no significant effect on either the sale price of homes in the neighbourhood or on the number of property sales. A single study observed a decrease in crime after the establishment of a residential treatment facility. However, the consistency in the results is important for the type of facilities examined –the research suggesting that the presence of a residential treatment facility does not adversely impact property values (Aamodt & Chiglinsky, 1989).

These findings have not changed with the advent of the 21st century, despite increasing suburbanization of many urban centres. Several studies underscore the need for public education concerning supported housing in general, noting that conventional fears about crime rates are not justified. The authors conclude that their research supports results from national opinion polls showing that neighbours' experiences with nearby supported housing are much more satisfactory than they predicted (Galster et al., 2002).

A rigorous, large-scale examination of the impacts of approximately 7,500 units of supported housing created in New York City over the past twenty years revealed that the prices of properties closest to supported housing—which are the properties opponents of supported housing claim are most likely to be affected by the development—increase in the years after the supported housing opens, relative to other properties located in the neighborhood but further from the supported housing. Prices of properties 500 to 1,000 feet from the housing may fall somewhat while the buildings are being built and as they open, but then steadily increase relative to the prices of properties further away from the supported housing but in the same neighborhood. These results accordingly suggest that over time, the values of homes near supported housing do not suffer because of their proximity to the housing. Unlike other studies, the effects on neighboring property values did not depend on the size of the development (number of units) or the development's characteristics, such as whether the development sets aside a certain number of affordable units for neighborhood residents. The impact supported housing has on property values also do not differ between lower and higher density neighborhoods (Armstrong et al., 2008).

One study undertaken in Toronto supported similar findings:

- No evidence that the existence of the supported housing buildings studied has negatively affected property values in the neighbourhood. Property values have increased in the period considered by the study.
- The opposition that existed to the houses when they were proposed has dissipated, with virtually no expression of negative attitudes found among immediate neighbours.
- Interviews with neighbours and 36 tenants and staff of both buildings indicate that the local economic “footprint” of each building is modest, primarily because of tenants' low

income. However, because they tend to have fewer choices than people with higher incomes, they shop at local convenience stores, pharmacies, coffee shops and restaurants. Some local store operators recognize the importance of tenants' business by offering them small amounts of short-term credit (De Wolff, 2008).

Overall, the research suggests that neighbors should have little to fear from the type of attractive and modestly sized developments that constitute the bulk of newly produced affordable housing today. However, some recent studies using new analysis techniques have pointed to some circumstances in which negative impacts are possible.

- This research suggests that the type of affordable housing matters less than the quality of the properties' design, management, and maintenance.
- Subsidized households and developments located in more vulnerable neighborhoods where lower priced homes were already depreciating were more likely to result in continued negative effects on property values.
- There was evidence of positive effects on property values in vulnerable neighborhoods related to the rehabilitation of abandoned or distressed properties as affordable housing.
- The quality of management influenced whether or not a development had negative effects on nearby property values.
- Several researchers found that larger, more concentrated affordable housing developments were more likely than smaller developments to have a negative impact on nearby property values. The results support the development of such units below 53 residents. In distressed areas, however, larger-scale affordable projects may in fact be desirable when they result in an upgrading of the housing stock at a scale sufficient to change the neighborhood trajectory.

(Center for Housing Policy, 2010)

Evidence: Impact on crime statistics

In the 2008 Toronto study, crime decreased in the study period but tenants in the supported housing experienced being targets for criminal activity. Tenants and staff needed to develop internal ways to protect themselves.

No published studies reviewed here reported increases in crime as a consequence of the existence of supported housing.

Solutions to NIMBY

Neighbors and community members may regard a supported housing development project from a Not in My Back Yard (NIMBY) perspective, but tension with neighbors is not inevitable. Design teams that seek to address neighborhood concerns from the beginning of this process can be rewarded with strong support for the project. It is important to approach the community from a positive stance of contribution to the community, rather than trying to mitigate a so-called "liability" for the community. Instead of asking how the impact of the supported housing project on the community can be minimized, developers should ask how this opportunity can be used to address neighbors' concerns regarding their neighborhood (Corporation for Supportive Housing Illinois Program, 2009).

The Toronto study made these recommendations:

- Create a streamlined, “single window” approach that assigns projects to senior city staff who are responsible for securing the necessary approvals.
- Ensure that all planning and zoning are neighborhood building processes and recognize that housing is a human right for everyone.
- The design and programming in supported housing should foster or strengthen several successful approaches: an atmosphere of support and security, internal communities among tenants, child and pet friendly spaces and openness to the neighbourhood. One study indicated that gardens are important, along with porches, benches, patios and community-use rooms.
- Housing providers should foster or strengthen a community liaison or community development function within their organizations, and support tenants who want to participate in neighbourhood-building actions and community organizations (such as a neighbourhood watch) (De Wolff, 2008).

The Fortune Society in New York was successful in addressing NIMBY issues when the organization built a new supported housing “reentry” project for post-incarceration individuals. They prepared a two-pronged comprehensive outreach strategy. On the one hand, they collaborated with the community, following the principles of respect, transparency, accountability, accessibility and “being a good neighbor” and, on the other hand, remained firm about their mission to provide phased permanent housing to formerly incarcerated persons without discrimination based on criminal histories. The strategy also took into account practical concerns of marshalling and allocating the necessary resources for the outreach effort. Some of the steps that they took:

- Stressed the importance of being transparent, addressing peoples’ concerns and issues immediately, maintaining a steady presence all of the time and helping to make the community safer.
- Reached out to elected officials who identified community stakeholders, who could help to build a support base and those who would oppose the development.
- Community liaison – the organization hired a trusted community member to attend community meetings along with a Fortune staff member who was formerly incarcerated.
- Senior staff engaged in a series of one-on-one meetings with individuals from community groups – this communicated a sense of commitment to the community
- Provided information and statistics to debunk stereotypes and myths about formerly incarcerated and nuanced information about the risks of recidivism
- Created a community advisory board to share information on the program design and solicit input

(Fortune Society, 2009)

- Factual issues can be addressed through supplying information, especially if produced by arm’s-length, independent organizations
- Emotional issues are best dealt with in small meetings with key people over time. Large community meetings in the public sphere are one of the least effective ways to reduce opposition as there are usually too many issues to address in-depth.
- Gain credibility by demonstrating previous successes

(Gilmour, 2012)

Most frequently, affordable housing supporters devote resources, as above, to engaging with community representatives regarding objections and actions that oppose a project. One author recommended that housing organizations as a whole attempt to change the rules of engagement by addressing the planning rules and protocols that exclude affordable developments and replacing them with more inclusionary and universal zoning principles. For example, in the UK, it is standard for planning policies to require a certain proportion of new housing developments to be available for affordable rental or sales. Housing affordability is 'hard-wired' into the planning process. Coalitions of housing providers, planners and advocates can often have an impact on the planning and policy environment (Gilmour, 2012).

RECOMMENDATIONS

A number of themes that point to recommendations have emerged from this literature review on models and elements of housing with supports and they are presented here as guidelines for future discussion and work. It is important to acknowledge that many of these represent the ideal or preferred future.

Note: Following each recommendation, in parentheses, is at least one exemplary practice related to that recommendation.

1. **Clearly defined and consistent use of terms** related to housing with supports, homelessness, and client groups by researchers and service providers would enhance communication, understanding and model comparisons. Descriptions that are based on adherence to specific, agreed-upon criteria, together with some consensus on the elements of each model of housing with supports and more precise operationalization of individual elements will facilitate dissemination and improved fidelity. While the Government of Alberta has defined many of the terms in the 10 Year Plan to End Homelessness, many initiatives in other provinces or countries noted that once their plans were put into practice, there was a risk of increased variability in adherence to criteria or fidelity. In the majority of cases, the elements of their models of housing with supports were not clearly explained in their plans.

(The protocols of the MHCC At Home/Chez Soi multi-site project are an attempt to define and operationalize key components and embed consistency in implementation)

2. **A wide range of housing options** is most often associated with improved and consistent outcomes:
 - Increased choice in housing fosters a sense of personal agency and self-esteem, which extends to other aspects of life.
 - Offering a broad range of appropriate options allows for selection of the most suitable type of housing. The immediate sense of isolation, loneliness and displacement when housed in permanent, independent apartments may lead to decreased functioning in some respects for some people and, in some cases, increased substance abuse.
 - The vast majority of homeless people express a preference for mainstream self-contained housing. Those offered the greatest housing choice are more likely to report greater satisfaction with their housing and neighbourhood.
 - There are some homeless people for whom independent scattered site housing will never be a viable option. If a wide range of options beyond scattered-site units is offered, they may find the type of housing best suited to them at the outset. This involves expanding options to also include supportive, social, shared or congregate housing options for those who would prefer these.
 - This review revealed that the linear transitional housing continuum and the housing first models each have their own drawbacks and advantages. It is not a matter of either/or, but of providing a full range of desirable, viable housing with supports options, each of which offer the option of permanency and stability, and none of which impose time limits on residents. This suggests that client-centred, flexible models would be able to accommodate both the option to stay permanently in supportive housing, and the option to move on to more independent living. This brings up the question about whether the distinction between “permanent” and

“transitional” housing continues to be useful, especially if there are no reasons for housing programs to impose time limits regarding a resident’s length of stay.

- It is important to include both low-barrier and high-barrier housing as options. As has been shown, some individuals show more success in abstinence-based situations, while others fair better in an environment of harm reduction.

(Building Changes in Seattle, WA; Greater Victoria Coalition to End Homelessness; Alberta 10 year plan to End Homelessness; MHCC At Home project all support a broad inventory of housing types and flexibility in approach)

3. **The provision of private self-contained units** is directly related to positive outcomes: Whether the accommodation itself is shared or private appears to be of greatest importance in predicting the pathway to or from homelessness. Living in self-contained units within a supportive housing environment enhances a sense of self-determination and normalcy.

In terms of housing with supports, studies have shown that most homeless individuals express a clear preference for self-contained units, and feel that diversity of age, gender, ability, health and mental health status and of tenure (i.e., mixed subsidized and market rentals) prevents “ghettoization”.

(Loft Community Services in Ontario: the Homelessness Initiative: [www.loftcs.org])

4. Any housing strategy needs to **consider the implications of housing location**. Housing located in crime-ridden areas can lead to tenants feeling unsafe and ill-at-ease. A lack of access to public transit, or unaffordable transportation costs can make people feel trapped, as can personal limited mobility, and/or the imposition of rules that limit independence.

Make efforts to keep people connected to their pre-homeless communities, families and other informal support networks. This is especially important for youth and families.

(Beyond Shelter in Los Angeles and research from the New York-based Furman Center)

5. Most municipal and provincial low-income housing plans aim to **blend dedicated housing into surrounding communities**.

Although not definitive, research indicates that dedicated buildings for supportive housing should be kept small so they can blend into the surrounding community, provide a home-like atmosphere, and avoid the institutional feel.

Residents prefer if there is no signage on supportive housing buildings that indicates what it is. This reduces stigma and facilitates community integration.

(Recommendations from the City of Calgary Affordable Housing Plan: www.calgary.ca/affordablehousing - “Straight Talk about Affordable Housing”)

6. Most housing initiatives ensure that rent and basic needs can be met. It is vital to **ensure adequate financial supports are in place as part of the housing intervention**.

Provide sufficient financial supports to, at the very least, meet basic needs and ensure they are not “at risk” of homelessness, nutritionally deprived, or in a constant state of worry that they will become homeless again. For women, as an example, ensure that they don’t face the same barriers of poverty, inadequate and unaffordable housing, discrimination, violence, and lack of access to childcare and other services, which caused them to become homeless in the first place

(Winnipeg Housing and Homelessness Initiative; Ontario Non-Profit Housing Association; Alberta Secretariat for Action on Homelessness)

7. Successful **supports to housing are broad-based and multi-disciplinary.**

In addition to housing and clinical/medical management, other supports such as employment, education, and peer support should be an important part of the services available to people who are at risk or are experiencing homelessness.

(The Portland Hotel Society and Delancey Street models include supports to improve residents’ education and employability, along with peer involvement.)

8. The current **description of “disability” is more inclusionary and can lead to less fragmentation** of supports and services.

Disability in some form is frequently a core cause of homelessness or a key barrier to a sustained solution. It is important to consider that the way disability is currently defined and understood by the World Health Organization (WHO) emphasizes functional status over diagnoses (the International Classification of Functioning, Disability and Health-ICF). The new system involves the elimination of distinctions, explicitly or implicitly, between health conditions that are 'mental' or 'physical.' Employing this definition could help develop supports and services that are less fragmented. The definition also makes explicit the physical and social environments. While still in the early stages, any housing with supports framework would benefit from keeping these new definitions in mind, as they hold promise in helping to develop more inclusionary housing projects.

(The World Health Organization, Statistics Canada and the Canadian Institute for Health Information are currently developing and piloting ICF-based reporting systems for use in rehabilitation.)

9. An **emphasis on stabilization in models of housing with supports can guide service planning** to help reduce unintended consequences of the systems of shelters currently in existence in most urban centres.

A ‘housing stabilization model’, as described by Culhane et al (2011), is an alternative that would focus more directly on helping people obtain and retain their own housing, with supports as required, than by the system of shelters that exists in many urban settings. It could be provided to all individuals, facing acute or imminent housing loss, with the basic idea that individuals and families would be appropriately diverted or relocated based on their circumstances, greatly reducing the need for congregate shelters and reducing individual exposure to victimization and dehumanization.

(More Than Shelter! A Plan to End Homelessness in Charlotte, North Carolina has modeled their plan on a housing stability model.)

10. Recommendation: Caution should be used when developing housing first approaches for populations other than those for whom it has been proven effective.

Due to the limited research on this model with other populations, “it is thus premature to conclude that this is an appropriate model for all other housing insecure groups”

- The Housing First literature to date suggests that this model is successful with several homeless sub-populations; however, women as a sub-population have been largely ignored. There is an absence of research examining culturally appropriate services for Aboriginal women.
- Housing first that places teens into independent living has been problematic with some youth. Some youth do much better in housing options that offer youth strong adult support (including mentoring); opportunities to experiment and explore (and to make mistakes within a safe environment); the chance to learn to nurture healthy adult relationships (including sexual relationships); and, to learn skills and competencies related to living independently.
- The current research data, specific to homeless people with active addictions, are not sufficient to identify an optimal housing and rehabilitation approach for this homeless sub-population. Therefore, policymakers should be cautious about generalizing the results of available Housing First studies to persons with active addictions.
- Effectiveness of the Housing First model has not been demonstrated for those struggling with combined addiction and criminal justice issues as well.
- In contrast to Housing First models, transitional housing, or studies examining the effect of the continuum of care model is strongly lacking. What results then, according to Kertesz et al. (2009), is that neither approach has been demonstrated consistently to be effective for all populations (Fotheringham et al., 2011).

11. Recommendation: Recognize there are gaps and limitations within the body of research:

- No empirical study has been able to distinguish the features of housing that are the active ingredients of housing that make the difference in residential outcomes for homeless people with complex issues.
- As with other aspects of housing implementation, there is little research available to provide definitive guidance on what organizational approaches work best for delivering supported housing. Supported housing is intended to be offered in the broader community by private landlords who rent directly to the tenant. Services are intended to be provided through separately funded case managers who link residents to services in the community. The general model reflects housing-services separation. It is not clear, however, if the housing and services necessarily need to be offered by different agencies.
- Whether to provide supports on-site or encourage tenants to navigate community service systems. This issue is particularly relevant in mixed-use and dedicated buildings. Tenants often prefer on-site services as they are more likely to use services that are convenient, particularly in programs where tenants are not required to engage in services. However, others perceive on-site services as overly intrusive and prefer to access services in the community (Patterson et al., 2008).

12. Any housing strategy must **recognize the complex trauma that extended and/or repeated homelessness incurs** that can result in survival strategies that remain in place for some time.

Some people who have been homeless for extended periods of time may have developed behaviours that served them well on the streets, but are no longer necessary once they are housed. It is crucial that supports and services provided in conjunction with housing are sensitive and responsive to the residual effects of the traumatic events experienced while homeless. Recovery from the experience of homelessness will be ongoing. One year of homeless experience requires several years of stable housed experience to heal. Being sensitive to the enormous disruption experienced by people when they move into housing after being homeless is critical to the individual making a successful adjustment to being a new tenant. It is important for the staff to understand the reasons why people acquire certain behaviours when they are homeless.

- a. Any framework needs to ensure some accountability for understanding trauma and its ongoing effects. Primarily, service providers need to see trauma-induced behaviours as “making sense”, given the person’s experiences, and understood as survival strategies rather than obstacles or evidence of a lack of cooperation.
- b. There also needs to be flexibility in approach to validate the experiences of persons who have been homeless and to acknowledge their need for self-protection and self-regulation, including the companionship of pets.
- c. To facilitate clients’ decision-making, support workers would need to fully understand the clients’ particular characteristics, strengths, fears, likes, dislikes, life experiences, etc. Support workers would need to be fully aware of which types of housing with supports models have shown to be more appropriate in terms of addressing (or not aggravating) particular issues of clients. They can then discuss the pros, cons and tradeoffs of different housing choices with the client to help them make an informed decision. (eg. for those clients who have spent a great deal of time sleeping rough, their adjustment to indoor living may be facilitated by offering housing with access to secured outdoor space, even as little as a balcony, to can ease a sense of feeling trapped.
- d. Recognize the range of barriers homeless individuals may face in achieving housing stability, and address them throughout (e.g., low self-esteem, low sense of control over own lives, social stigma). Many researchers and providers argue that treatment strategies have little or no effect and are often declined by clients unless they feel safe and satisfied with their housing.
- e. Remain cognizant of differences of experience, including strengths and need related to age, gender, sexual orientation, cultural background, length of time spent homeless, type of homelessness experienced, number of homeless incidents.
- f. The importance of ongoing transgender-related staff training is fundamental to serving transgender youth in a respectful and supportive manner. It is also recommended that housing provides private shower, bathroom and sleeping spaces. If housing is gender-specific, youth should have the right to choose where they wish to be, based on their gender identity, without further questioning or interrogation.
- g. Recognize and address Social Isolation. Residents often feel isolated and lonely and may return to the streets as a result. Studies have indicated this can often be prevented through the development of strong relationships with support

workers who are available “24/7”. Discrimination, internalized stigma, and lack of opportunities for meaningful participation were identified as key barriers to social engagement within their communities. Whether in scattered sites or supportive housing, community building approaches which emphasize inclusion, valuing peer knowledge and participation in decision-making (i.e. self-regulated housing) best address social isolation and safety issues, while enhancing individuals’ sense of personal agency.

(Pathways to Housing was designed to meet the homeless person “where they are”; other projects have followed suit. For pet owners who are homeless: Dog Trust Hope Project in UK; shelters in Halifax and Vancouver – more details in Appendix B)

13. Given the data on homeless families, ensure there are housing with supports options to accommodate large families.

Housing with supports for homeless immigrants/refugees/refugee claimants would need to offer units large enough to accommodate larger newcomer families. The same may be true for Aboriginal families that extend their family obligations beyond the nuclear unit. A promising practice that would meet this need is inclusion of flexible housing units that can individually house separate smaller households when needed and also have the capacity to open (via common doors or moveable walls) to connect multiple spaces. Long-term affordable transitional housing with optional supports (up to three years) has proven to work well with newcomers.

(Housing initiatives in South Los Angeles, part of Beyond Shelter, [e.g., Central Village, Mason Court, Avalon II] are “mixed-use” projects consisting of one-, two- and three-bedroom apartments to accommodate very low-income families. They are designed to provide safety and security and to encourage resident participation and support for culturally-specific practices.)

www.beyondshelter.org/aaa_programs/aaa_programs.shtml

14. Provide the opportunity for and encourage client decision-making.

A comprehensive, positive client-directed approach to supports has been found to be key in building self-esteem, reducing self-doubt, apathy and a sense of futility, and increasing a sense of self-determination. Informal or formal involvement of formerly homeless individuals in the decision-making and management of their housing residence, which also promotes integration and reduces isolation, can further enhance these outcomes. Allowing participants to direct their treatment does not imply a laissez faire approach to engaging participants. There needs to be an integration of motivational approaches and alternative illness management in day-to-day practice, especially regarding challenging behaviours that could strain landlord relationships and jeopardize housing.

The exception to voluntary participation in treatment or reduction of substance use is with families. Unlike with adults alone, providers working with homeless families with violence, mental health, addictions and/or substance abuse issues must take into account the vulnerability, needs and safety of children in determining how “voluntary” participation in recovery should be.

(Some of Beyond Shelter’s key elements of “service-enriched housing” are: voluntary participation of residents in programs, services and activities; resident participation in the

decision-making process; residents, management and service providers work together as a team. Downtown Emergency Service Center in Seattle, WA – while this is a ‘harm reduction’ approach, efforts are directed at engaging residents in discussions about addiction and/or mental illness.)

15. Better housing outcomes were attained **when clients were meaningfully involved in the housing intervention and case management intervention**. Whether in scattered sites or supportive housing, community building approaches which emphasize inclusion, valuing peer knowledge and participation in decision-making (i.e. self-regulated housing) best address social isolation and safety issues, while enhancing individuals’ sense of personal agency.

(Shelter, a NGO in the UK, has had significant success with involving clients. The Clubhouse model, outlined by the International Center for Clubhouse Development, supports the involvement of clients with mental illness in the residential and support functions of their programs.)

16. By “**de-linking” housing from supports**, Housing First programs can target individuals who have declined rehabilitative treatment or for whom treatment has been unsuccessful. They can become housed without committing to treatment, and they can lose their housing without jeopardizing their supports.

(This is the core concept for Housing First approaches, which has challenged the traditional paradigm.)

17. People who are most likely to **benefit from transitional housing** include: those who are recovering from traumas; lack social networks; have a background of multi-generational poverty; are exiting institutions without independent living skills; need skill training in order to obtain a living wage; have mental health problems; are attending addiction treatment; are physically or mentally disabled; or are recent immigrants.

(Beyond Shelter, for homeless families originated in Los Angeles; Sage House, in Winnipeg, YWCA Transitional Housing in Regina, Calgary, Edmonton and other Canadian cities)

18. The **design and programming of housing and supports** should foster or strengthen several successful approaches: an atmosphere of support and security, internal communities among tenants, child and pet friendly spaces and openness to the neighbourhood.

(Data and reports from the Furman Center at New York University is a resource for good practices related to design and environmental innovation that addresses these issues.)

19. Any housing initiative should include a **community liaison or community development function and support tenants who want to participate** in neighbourhood-building actions and community organizations.

(New York/NY III project and the Fortune Society have actively encouraged residents to be proactive in their neighbourhoods.)

20. There have been more successes with NIMBY when initiatives **proactively address neighbourhood apprehension and engage directly in community building**.

New affordable and/or supported housing projects can minimize future neighbours’ concerns by being transparent, anticipating and responding to questions, providing

information to help reduce fears and work to resolve issues immediately, maintaining a steady presence all of the time and demonstrating how the project will make the community safer.

(The Fortune Society has had success with integrating in their neighbourhoods and in collaborating with communities to address issues that naturally arise with a future project.)

21. There is clear evidence that the **involvement of formerly homeless persons in the design and management of housing initiatives and the inclusion of residents in the housing operations** have very positive outcomes for the residents and for the housing initiatives. This is a recommendation that is universal but often it is not fully implemented. It cannot be emphasized enough that there should be pathways for the recruitment, orientation and support for clients and residents to participate from development through to ongoing implementation.

(Sandy Merriman House in Victoria, BC – this is an emergency shelter for women; in 1994, the planning committee recruited disadvantaged women who were interested in being trained in construction skills to work along with design and renovation professionals. The house also has a magazine that is written and published by residents. Cleveland, Ohio, has developed a manual that outlines the parameters for resident involvement in decision-making (City of Cleveland, 2010))

22. Expand indicators of program success:

- An over-emphasis on quantifiable outcomes, such as employment, can result in an emphasis in providing supports with measureable outcomes and neglecting to provide supports with less quantifiable outcomes, such as social inclusion.
- Broaden indicators of success beyond housing stability: Because it has been found that providing housing with supports to homeless people with complex issues provides the context for them to then address other issues, housing stability has become a proxy for measurement of overall program success. Housing stability is a means to an end. Other measures that might also be considered include hope for the future, having a job, enjoying the company and support of others, and being involved in society, social interaction, financial well-being, satisfaction with their housing, etc.
- Recognize that tradeoffs may exist in terms of outcomes: for example, many studies indicate that high-control programs seem to have better reunification and self-sufficiency outcomes, but their attrition rates are high. By contrast, low-control programs may have higher residential stability but are not as successful at helping families reunify or move to greater economic self-sufficiency.

BEST AND PROMISING PRACTICES

This is a list of examples of good, best and promising practices in the area of housing and supports. It is meant to serve as an example of how some problems are addressed in Canada. Some best practices examples that are unique or pioneering are described in more detail in Appendix B.

Facilitating access to services – Province of Alberta

Without official identification, a homeless person cannot access certain community services and programs. This barrier can create a domino effect that makes it more difficult to obtain a permanent home.

In 2009, the Government of Alberta formed a committee to help homeless Albertans acquire identification in order to increase access to vital assistance programs and services. Two significant barriers that homeless people face when trying to obtain ID are having an address and verification of identity. To address this, the committee developed two new processes to help homeless Albertans obtain government-issued ID cards:

- The Address Authorization process authorizes the use of a shelter or drop-in's address for a homeless person applying for an Alberta Identification Card.
- The Identity Certification process certifies the applicant's identity. It allows a homeless or recently housed person to work with a service provider to verify their identity and obtain acceptable supporting documents in order to apply for an Alberta Identification Card.

Between October and December 2010, training to deliver ID services to the homeless was provided to government-funded shelters, drop-in centres, and homeless-serving agencies in seven communities in Alberta.

Prevention

Most Commonly Offered Activities

- a) Counselling and Advocacy
 - a. Information and referral about available resources
 - b. Budgeting and debt reduction, handling credit and improving credit rating/history
 - c. Links to entitlements and community resources
 - d. House search assistance
- b) In-Kind Emergency Assistance
 - a. Food, clothing, transportation, furniture, medical care
- c) Cash Assistance to Maintain or Obtain Housing
 - a. Deposits (first month's rent, last month's rent, security)
 - b. Arrearages (rent, mortgage, utilities) to prevent eviction or foreclosure
 - c. Moving Costs
- d) Links to More Sustained Help
 - a. Mental health treatment
 - b. Substance abuse treatment
 - c. Training and employment assistance and support, job search
 - d. Links to benefits: Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), food stamps, housing subsidies, and local programs

Less Commonly Offered Activities

- a) Other Cash Assistance
 - a. Automobile loan or repair
 - b. Short-term rental payments for people with disabilities while waiting for SSI
 - c. Special funds associated with Memoranda of Understanding arrangements, described below.
- b) Legal and Other Assistance to Retain Housing
 - a. Mediation with landlords around rents, heat or utilities, repairs, hazardous conditions
 - b. Arrangements through Housing Courts, including mediation, provision of counsellor, fee return to landlords, special funds
 - c. Support services to assure housing retention once families or singles move to housing (i.e. Assertive Community Treatment for people with serious mental illness)

Mainstream Agencies Assuming Prevention Responsibilities for Own Clients, Inmates or Consumers

- a) Develop specialized housing (various forms for people with serious mental illness, halfway houses for corrections)
- b) Support services to assure housing retention
- c) Employment links and services
- d) Discharge planning, especially linked to housing, services and employment
- e) Specialized units, trained staff

Memoranda of Understanding or Other Formal Interagency Arrangements to Prevent Homelessness for Vulnerable Populations

- a) Special funds for cash assistance
- b) Hotlines and other mechanisms to alert agencies to risk situations
- c) Special training and staffing
- d) Centralized resources to resolve housing emergencies
- e) Mental Health Courts (prevent people with serious mental illness cycling through jails, shelters)
- f) Planning and coordination so code enforcement (condemning or otherwise closing housing, temporarily or permanently) does not produce homelessness

Sometimes Mentioned as Deep or Long-Term Prevention Strategies

Antipoverty Activities

- a) Job training, continuing education, skill development
- b) Literacy, adult basic education, English as a second language
- c) Affordable housing development

No eviction policies – meeting the needs of the ‘hard to house’ – Portland Hotel Society

Portland Hotel Society, Vancouver BC (Mental Health Commission of Canada, 2010)
Portland Hotel Services Society’s (Vancouver) ‘no-eviction policy’. “The nuances of this policy and its effects on the residents’ lived experiences afford a greater understanding of how a

housing provider such as PHS reframes their mandate to allow their residents to live in dignity. It answers the questions “Who are the hard to house and how can their needs be met” and “What role do housing management policies perform and how can these policies reflect this population’s needs” (Gurstein & Small, 2005)

Harm Reduction approach to housing - Walking to Wellness, Nanaimo, BC

This residential housing and support program is designed with an Assertive Community Treatment (ACT) model of service delivery for persons with substance use. A multi-disciplinary team provides intensive case management services to clients in their own environment 8:30 a.m. to 9:00 p.m. six days a week. A 24-hour back-up crisis service system is available.

Follows a harm reduction philosophy in all aspects of treatment and service delivery. The team accepts all clients “where they are at” regardless of their substance use, and aims to meet their needs with creative and relevant clinical responses. There are no program rules to limit substance use in buildings where clients have their own self-contained unit. (Serge et al., 2006; Mental Health Commission of Canada, 2010)

Abstinence for substance use with supportive housing - Mainstay Residence, Winnipeg MN

The model of service delivery includes 24-hour on-site staffing. Each resident is also attached to a member of a multi-disciplinary team. Residents are expected to be abstinent or working towards abstinence. Drugs, alcohol or inhalants of any kind are not permitted in the rooms or common areas of the building. Residents may be sent temporarily to another treatment facility if they suffer a relapse, but are not discharged from the program for using. This program has modified its approach to include housing as part of the responsibilities for support workers as a way to increase tenure in housing, which has been successful. (Serge, Kraus, & Goldberg, 2006; MHCC, 2011)

Clubhouse Model for housing and supports - Potential Place, Calgary AB

Potential Place owns and operates two apartment complexes, which house 27 people with mental illness in individual units. The tenants participate in the property management of the buildings, in accordance with International Clubhouse guidelines. (Mental Health Commission of Canada, 2010)

APPENDICES

APPENDIX A

Housing for People Living with Schizophrenia: Dilemmas of Care and Control.

Barbara Schneider, University of Calgary, and Jamal Ali, Laurie Arney, George Benson, Cindy Calderbank, Claude Mathieu, Michele Misurelli, Mary Mitchell, Dale Silbernagel, Mark Sunderland: Members of the Peer Support Unsung Heroes Program, Schizophrenia Society of Alberta, Calgary Chapter

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The following recommendations are from a participatory action research project undertaken by a group of people with schizophrenia who expressed a desire to investigate housing for people with schizophrenia, an area that they saw as a significant problem, both from their personal experiences and from their observations of others' experiences. The project was carried out under the guidance of a university researcher.

Members of the research group identified the tension between care and control in relations between people with schizophrenia and their medical and housing service providers as the main theme arising from the research. On the one hand, the participants in this research want, feel they need, and appreciate, the help and care they receive from mental health professionals, government agencies, housing and other social service providers, and family members. On the other hand, to receive that care, they must submit themselves to a variety of forms of what they regard as intrusive surveillance and coercive control over many (perhaps all) aspects of their lives. If they are not willing to do this, they run the risk that care will be withheld. However, they are deeply ambivalent about the control aspects of care: while they may chafe under it, they sometimes also want and appreciate the control that is exercised over them to prevent behaviours that have in the past led to instability.

Housing for People with Schizophrenia: Recommendations for Service Providers

"The recommendations below were produced as part of a participatory action research project that investigated housing for people with schizophrenia. The research was conducted by members of the Peer support Unsung Heroes Program, Schizophrenia Society of Alberta, Calgary Chapter, led by Dr. Barbara Schneider from the University of Calgary. The main theme arising from the research is the tension between care and control in relationships between people with schizophrenia and their housing and medical service providers. These recommendations reflect the voices and views of people with schizophrenia."

Providing Care

- Have a central agency for the city that knows about all the housing options for people with mental illnesses. Make sure that one person from this agency follows a person right through the system, A to Z, from homeless to housed, so people do not get lost in the system.
- We need an advocate to mediate disputes between people with mental illnesses and housing providers or landlords.

- Provide more education about mental illness to housing service providers and landlords. Many lack compassion and do not treat us with respect and dignity.
- Families can be an important stopgap that catches you before you fall to the streets. Provide education for families about different housing options and offer more support for families.
- Provide support to help us as we get more independence. We are very fragile when we start to do things and need help with doing taxes, saving money, learning about insurance, providing for ourselves in the future, and managing stress.

Reducing Control while Providing Care

- Don't ask us for compliance. Work with us to help us make choices but do not tell us what we have to do. We do not want to be forced to live the way you think we should live.
- Don't make us share with roommates unless we are willing to.
- The fact that we are living with a mental illness and on disability pension does not mean that you have a right to intrude into our lives. Don't ask us to expose our whole lives.
- Simplify the AISH (Assured Income for the Severely Handicapped) system. Right now, if you start to work, the paperwork required by AISH is overwhelming. It makes you not want to work. As you start working, it should be easier instead of more complicated.

Expanding Access to Housing

- We should be able to live where we want to live. Most of us dream of living in our own homes in the community. Help us to make this a reality.
- Housing should be permanent. We should not be moved without our consent. We should not have to move just because we reach age 65 or don't "fit in" to particular housing.
- Housing should be flexible to accommodate people's needs. Provide more different ways of housing people, including people who have pets.
- We need rent controls and more subsidized and affordable housing. Society has to make this a priority. Provincial and federal governments could give tax incentives for affordable housing or require that builders make a certain percentage of their units affordable housing. We must find the political will to have more subsidized and affordable housing.

APPENDIX B

DETAILED DESCRIPTIONS OF BEST PRACTICE PROJECTS

1. At Home/Chez Soi Project, Mental Health Commission of Canada

A pragmatic, mixed methods, multi-site field trial of the effectiveness of Housing First in Vancouver, Winnipeg, Toronto, Montreal and Moncton, is randomising approximately 2500 participants, stratified by high and moderate need levels, into intervention and treatment as usual groups. Quantitative outcome measures are being collected over a 2-year period and a qualitative process evaluation is being completed. Primary outcomes are housing stability, social functioning and, for the economic analyses, quality of life.

Following are some of the learnings to date in the project.

Choice over housing fosters a sense of self-esteem and growing control over other aspects of life beyond housing. However, providing housing choice in practice requires broadening the options available to participants to include other options in addition to scatter-site apartments, such as supportive, social, shared or congregate housing options for those who would prefer these. Narrative interviews suggest that the latter options may be preferred by individuals concerned about isolation, or about having very high support needs. The fidelity reports remind the teams, however, that providing such options does not alter the need in principle to maintain separation of the housing and support aspects of the model.

Early access to housing is critical to the engagement process; housing procurement strategy is crucial in facilitating such access in light of challenges such as tight housing supply and discrimination; towards this end, the results highlight the importance of having a nimble agency, whose actions are directed primarily by the clinical team and the needs of participants, and whose interests are not unduly compromised by the need to maintain landlord relationships for other client groups.

Democratic decision-making is acknowledged as a major strength of the project to date; however the complex and multi-layered project would benefit from clearer and more efficient governance and accountability procedures going forward.

2. Portland Hotel Society (PHS) – Vancouver, B.C.

The Portland Hotel Society (PHS) in Vancouver's Downtown Eastside, aims to promote, develop and maintain supportive affordable housing for those whose housing needs are largely ignored and, as a result, are socially isolated. Residents are adult individuals who are "hard-to-house" and at risk of homelessness due to their physical and/or mental health, behaviour, substance dependencies, and past criminal involvement. Their multiple diagnoses impede their ability to secure housing because they are deemed problematic by housing providers. Besides low income, they have job insecurity and may lack sustaining personal relationships.

In 2005 the PHS had 450 housing units in seven buildings, with various medical personnel on staff, hospice care, plus social events and outings, in-house needle exchange, methadone

program, community art centre, life skills centre, two community-run cafes, radio station, and more.

The PHS's housing management policies reflect the needs of the "hard to house" population. Their approach places the tenants' rights to housing as primary. It has few rules and regulations. Their 'no-eviction' policy, for example is regardless of a resident's behavior, underscoring the program's deep commitment to acceptance and finding creative solutions to problems. Emphasis is placed on accepting residents where they are at, and being flexible, responsive and creative in working with them to remain housed and as healthy as possible.

The Portland Hotel has succeeded in providing long term housing for people with mental illness, addictions and other problems, and in reducing their susceptibility to harm. Approximately 40 percent of residents stay at the Portland Hotel for about 10 years, while the balance of residents stay 4 to 6 years. This contrasts dramatically with the prior history of residents, who typically registered 6 to 8 addresses – or none at all – in the year before moving to the Portland Hotel. The Portland Hotel has also succeeded in creating stable access to vital services for its residents.

A valuable social outcome of the program is that residents have a home and a community where they feel accepted and respected, in sharp contrast to previous life experiences. Beyond the obvious requirement of substantial and stable funding from funders who appreciate the economic and social value of this type of program, a critical success factor is staffing. Who is hired and how they are supported in their challenging jobs are essential considerations. Staff must be genuinely flexible, non-judgmental and compassionate in dealing with residents, who often direct dysfunctional attitudes and behaviours towards the staff. The PHS recognizes the complexity of behaviours of their residents by understanding the life trajectories that precipitated the behaviours.

While the specificity of the PHS may not be generalizable, its central theme of organizational reflexivity can be. Reflexivity refers to an on-going examination of the underlying assumptions and narratives that drive practice.

(Gurstein & Small, 2005)

3. The New York/New York III Initiative – supported housing extended to other populations

This initiative extended the supported housing model to homeless populations without serious mental illness to include families with children, transition-age young adults, persons living with HIV/AIDS, and people with substance use disorders.

This was comprised of 500 scattered-site units, which were permanent subsidized housing linked to flexible case management services. The program followed the practice of "master-leasing" the units from private landlords and then sub-leasing to tenants, becoming both the landlord and services provider for tenants. Tenants paid no more than 30% of their income toward rent and utilities.

The staffing is largely comprised of non-clinical staff, with the assumption that clinical, medical, and behavioral health services will be provided through linkages and referrals to mainstream service providers.

Master-leasing structure may have increased access to apartments, but possibly reduced tenant choice and satisfaction.

The use of separate housing specialists appeared to allow programs to ease some of the challenges and potential role conflicts that come with master-leasing.

Renting two-bedroom units initially seemed to be a good idea, but program staff indicated that this practice frequently resulted in conflicts between tenants, decreasing housing satisfaction, quality of life, and stability.

Program staff reported that tenants had numerous problems maintaining welfare benefits because of policies around substance use in New York City's public assistance (PA) program.

Supervision reinforced the Housing First approach, and helped case managers cope with the difficulty of seeing tenants struggle with addiction.

Case managers in all programs reported that contending with the slowness of change and missed opportunities to make progress among tenants was a significant challenge.

The ability of supportive services to help tenants progress towards their goals was often frustrated by system-wide barriers faced by tenants. For instance, tenants seeking to obtain employment often faced difficulty finding jobs due to their histories of incarceration.

Semi-structured recreational and socialization activities were a critical component of Population E supportive services. Program staff viewed these services as helping tenants overcome loneliness, isolation, and the lack of experience with positive social interaction.

A reported best practice was explaining rights and responsibilities to tenants once at the lease signing and then yearly reiterating and re-explaining the information.

Program staff described outcomes that captured quality of life improvements ordinarily missed by traditional measurement tools.

One way to avoid agency- program misalignment might be to monitor (i.e., through program audits) for agency-program misalignments, and through a technical assistance provider, work with staff to identify and resolve points of conflict. In addition, issues with mainstream service systems underline the need for systems-level assistance from public agencies.

The implementation of Housing First for this population entails a significant shift in perspective and practice and requires careful selection of agencies, deliberate program planning, assistance with startup, and ongoing guidance, technical assistance, and reinforcement. One means to improve the selection of agencies might be to require, in solicitations or Request for Proposals, evidence that the agency supports the Housing First model, as well as auditable examples of how the agency's administration will support implementation.

Creating Housing First units for this population through a larger funding initiative was found to be a viable means of supporting effective program implementation, but program standards applied to other supportive housing models should not automatically be imposed on those using a Housing First approach. Any effort to include Housing First strategies as part of a larger supportive housing initiative like NY/NY III should also make use of program standards

consistent with, or specific to, Housing First.

(National Center on Addiction and Substance Abuse at Columbia University, 2012)

4. Delancey Street – Residential Programs for the “Hard to House”

Delancey Street is a residential self-help organization in the U.S. for former substance abusers, exconvicts, homeless and others who have hit bottom. Started in 1971 with 4 people in a San Francisco apartment, Delancey Street has served many thousands of residents, in five locations throughout the United States-New Mexico, New York, California (both LA and San Francisco), and Massachusetts. Residents at Delancey Street range from teenagers to senior citizens, and include men and women and all races and ethnicities. The average resident has been a hard-core drug and alcohol abuser, has been in prison, is unskilled, functionally illiterate, and has a personal history of violence and generations of poverty.

Residents who have been at Delancey Street awhile interview all applicants. The minimum stay is 2 years; the average stay is 4 years. There are three rules: no drugs or alcohol, no physical violence, and no threats of violence. The program runs like an extended family where everyone is expected to contribute. It is completely self-governed with councils of residents dealing with one another on issues such as housing, rule violations and education.

Delancey Street uses an educational model rather than a therapeutic one to solve social problems and starts by teaching some of the personal skills needed to break through bad habits and interact with others successfully. Residents learn about themselves and how to develop their strengths through actually practicing life skills, living, working, and interacting in the community. The organization's programs educate participants on different strategies on how to learn to lead a productive crime-free/drug-free life of purpose and integrity. When mistakes are made, they acknowledge them, take the consequences (punishment is extra work) and most importantly, because they are in a safe environment they can fix the mistakes. In this way, they replace old self-destructive habits with new strengths, talents, and a sense of responsibility.

When ready, residents can enter one of the organizations employment training schools and rehabilitation courses, where training and other educational skills are provided by staff and even more experienced residents. Tutoring is offered to residents to complete a high school equivalency education followed by college courses, and for those who stay 3 years, they have a post secondary academy accredited by the State of California. Delancey Street's own residents do the teaching and tutoring.

“When mistakes are made, we learn to acknowledge them, take the consequences (our punishment is extra work, usually doing the dishes) and most importantly, because we are in a safe environment we can fix the mistakes. In this way, we replace old self-destructive habits with new strengths, talents, and a sense of responsibility.”

When ready to graduate from Delancey Street, residents get a job and live in and work out for several months, saving their money in the Delancey-managed credit union, and paying rent until they can move on to continue their new lives in the mainstream of society. Economic

development and social entrepreneurial boldness are central to the model's self-sufficiency. They are also central to teaching the disenfranchised to develop their talents and strengths and not simply to focus on their problems, and thereby gain empowerment, self-reliance and a strong sense of pride and dignity in their own achievements. Participants "enter with a history, leave with a future."

5. Sage House (Winnipeg, Manitoba): A Welcoming Space For Street-Involved Women

Sage House is a street women's health outreach and resource centre. It is a program of Mount Carmel Clinic, Canada's oldest community health centre. The program is a good fit for the clinic, since they both focus on population health and community development.

The goal of Sage House is to improve the health and safety of street-involved women and transgender people living as women. It provides a variety of services on-site, through street outreach and in programs offered with partner agencies. It offers a welcoming, safe environment, where women are encouraged to explore their choices and support each other. Meals, laundry, toilet and bathing facilities are available, and the main floor is wheelchair accessible.

The house serves mainly adult women; youth must be referred to Child and Family Services.

Sage House also works with the Elizabeth Fry Society, which provides services for women who are in conflict with the law.

There are two staff on hand when the drop-in is open, and a nurse is available on-site during drop-in hours.

Services include: nursing care; testing for HIV, hepatitis A, B and C, STIs and TB; health education; pregnancy testing; condoms and safer-sex supplies; counselling and support; referrals to other services; advocacy; laundry; bathroom; kitchen; someone to talk to; volunteer opportunities; bingo; art therapy; clothing; dinner on Tuesday and Friday; a Sobriety Support Group; a Solvent Users Group; Biindigen Outreach Project (see page 114); and a monthly newsletter. Sage House provides shampoo, conditioner, towels and even changes of clothes, so people can wear pajamas while they are doing their laundry. There is a backyard where women can have picnics and barbecues, and smoke.

Sage House has a counsellor who does individual counselling. As well, the outreach workers have a room in the house where they can hold private discussions with women as needed. Sage House also offers a program called Dream Makers for women who are further along in their healing journey and want to give back to the community through peer support work. A doctor's office is just a short walk away from the house.

Funding for Sage House comes mostly from the Winnipeg Regional Health Authority. As part of cost recovery, the house also rents its garage to auto mechanics (Canadian Harm Reduction Network/Canadian AIDS Society, 2008).

6. 1811 Eastlake, Seattle – Downtown Emergency Service Center [DESC]: housing

for severe concurrent disorders

- Participants were drawn from a rank- ordered list of chronically homeless individuals who incurred the highest total costs in 2004 for use of alcohol-related hospital emergency services, the sobering center, and King County jail
- Participants were pre- dominantly male (94%) with a mean age of 48 years. The sample was ethnically diverse, with 39% identifying as white and 28% as American Indian/Alaskan Native.
- Participants reported high rates of acute and chronic medical illness, a mean of 16 alcohol treatment episodes, and minimal periods of stable housing during nearly 2 decades of homelessness.
- In the year prior to the study, housed participants accrued a median \$4066 per month per individual of use costs. Thus, in the year prior to intervention, \$8 175 922 in costs were accrued by the 95 individuals who received housing. Individual median costs per month drop notably after 6 months (\$1492) and again at 12 months (\$958), and total costs for the housed group for the year after enrollment in housing were \$4 094 291.
- Finally, length of time in housing was significantly related to reductions in use and cost of services, with those housed for the longest period of time experiencing the greatest reductions.
- The study also demonstrated that individuals in the housed group experienced reductions in their alcohol use and likelihood of drinking to intoxication over time. The HF intervention was associated with substantial declines in drinking despite no requirement to abstain from or reduce drinking to remain housed.
(<http://www.desc.org/1811.html>)

7. Accessible Housing: The Seven Basic Principles of Universal Design

- Equitable. Useful to people with all sorts of abilities. Provides the same means of use for all; does not segregate any user; makes the design safe and appealing to all.
- Flexible. Accommodates a wide range of preferences and abilities by providing choice in methods of use, allowing right- or left-handed application, adapting to the user's pace.
- Simple. Easy to understand and natural to use, regardless of the user's experience, knowledge, language or attention span. Eliminates complexity where possible, uses common cues and provides effective prompting and feedback.
- Perceptible Information. Communicates necessary information to the user regardless of the user's sensory abilities. Uses different modes to present information; makes them "legible" whether they are words, pictures or shapes; and makes the design compatible with other techniques or devices used by people with sensory limitations.
- Tolerance for Error. Assuming the user will make mistakes, the design minimizes the hazards of consequent accidents. Provides appropriate warnings and fail-safe features and discourages unconscious action in tasks that require vigilance.
- Low Physical Effort. Allows the user to maintain a natural body position, requiring only reasonable exertion, and minimizes repetitive actions and sustained physical effort.
- Easy to Approach and Use. Accessible to approach, reach and manipulate, regardless of the user's body size, posture or mobility. That means providing a clear line of sight to

important elements and placing all components where they can be reached by a seated or standing user, accommodating various hand and grip sizes, and making room for assistive devices or people.

(Holtzman, 2006)

8. Examples of housing and support practices for homeless or at-risk youth

Foyer, (Adelaide, Australia) is not simply a ‘group home’ by another name. Rather it is a new response to youth homelessness and unemployment that offers a different kind of transitional housing and seeks to develop talents in young people, rather than simply trying to change their deficits. It is not just a model of supported housing; rather it is a model for working with young people that supports them in becoming responsible and contributing adults.

The Foyer approach has many advantages. It addresses the causes of the ‘no home - no job – no home’ cycle that many youth who are brought up in poverty, care, or other stressful experiences find themselves in. It provides resources, opportunities and support to youth who have not had the kind of experiences that many other youth have in preparing for independent living, the workforce, or quality relationships. The Foyer approach is based on solid research evidence relating to the risk and protective factors of poverty, unemployment and homelessness. The model has been adapted and implemented with success in several countries. The Foyer has been applied in a broad range of contexts, and much has been learned about the effectiveness of the model. What makes the model effective is its focus on adolescent development, housing and income, education and training, and bringing appropriate supports to bear on young people’s transitions from care. (Gaetz, 2012)

The Doorway, in Calgary, provides support in 13 life categories (housing, employment, education, finances, drugs/alcohol, legal, personal, problem-solving, planning, identification, volunteer, leadership and “other”). Successful program models such as this underline how essential comprehensive supports are in helping a youth to transition out of homelessness. (Raising the Roof, 2009).

Youth at **Eva’s Phoenix**, in Toronto, live in shared townhouse-style units with access to common areas. While at Eva’s Phoenix, youth develop the skills to live independently through goal-setting exercises, workshops and hands-on programs that are delivered in a supportive environment.

In combination with a Mentorship Program, youth are able to build stable support networks outside the social service system. Peer mentors and one-to-one mentors provide a range of support to youth including running cooking classes, conducting leadership development activities and supporting the efforts of youth to successfully manage independent living. Youth living at Eva’s Phoenix must be involved in a training or employment program. (Raising the Roof, 2009)

Choices for Youth, St. John’s, Newfoundland

Current Core Programs: Supportive Housing Program

The Supportive Housing Program, which utilizes an outreach model, has highlighted our efforts as an organization to continue to respond and adapt to the needs of youth. A key feature of the program is its emphasis on attaching supports to the individual, regardless of their housing

status, therefore allowing those youth who struggle with housing stability to remain in the program (Raising the Roof, 2009).

New Affordable Housing with Education and Employment Supports

Choices for Youth is currently in the process of developing a new housing model that will provide longer term housing for street-involved youth in the St. John's area (based on the Eva's Phoenix model). This project will fill a significant gap in housing in St. John's by combining safe, affordable housing with on-site support, a basic literacy and math skills program, and an employment preparation program. The aim of the project is to take a multi-faceted, holistic approach to recurring homelessness by removing lifestyle, housing, education and employment barriers. Youth will be supported in learning the skills to live independently and securing opportunities to make healthier lifestyles more sustainable (Raising the Roof; 2009).

9. Ali Forney Centre New York, housing for GLBTQ youth

- Emergency housing is low-barrier apartments that provide a home-like environment to help the youth believe that they are worthy of having a home. Also, they do not want the youth to become accustomed to surviving in a “warehoused system” of the regular shelter system. Youth stay in emergency housing for 1 to 6 months.
- They then move on to Transition for Independent Living housing for up to one year.
- Then on to Transitional Living Program in which youth are required to have full-time (35 hours/week) work/education schedule. Up to two-years.
- Direct on-site service provision is strengths-based, identity-affirming, holistic, trauma-informed (“what happened to you?” vs. “what’s wrong with you?”) with progressive thresholds and prolonged engagement.

All housing programs provide shelter, food, clothing, individual and group counseling, case management, transportation, mental health services, medical and dental referrals, and legal assistance (Shelton, 2011).

10. Fairway Woods in suburban Langford, near Victoria – housing for older homeless persons

Located in suburban Langford, near Victoria, B.C.. Approximately three quarters of the tenants are men; one-quarter are women. The median age group is 55-64 years. Over half of the tenants are dependent on welfare; others live on pension income. The tenants moved to Fairway Woods from a variety of living arrangements, including a detoxification facility, hospital, other Cool Aid housing projects, shelters and substandard housing.

A majority of the tenants have multiple and complex diagnoses, which include mental illness and addictions, as well as physical health problems associated with age, such as arthritis, heart problems and diabetes.

Before moving to Fairway Woods, many of them felt “anxious,” “angry,” “isolated” and “stuck” much of the time. A typical 24-hour day was described as “lonely and a waste of time.” Since moving to Fairway Woods, they have stability in their lives. Although not all of their troubles have disappeared, they feel “relieved,” “more secure” and glad that their chronic conditions are “under control.” They are “drinking less,” “socializing more,” “more confident,” “getting more

exercise” and “sleeping better. They rarely see “bad company.” Their self-rated coping skills have escalated.

The four aspects of Fairway Woods that contribute most to the tenants’ quality of life are:

- the quiet, suburban setting,
- the predictability of everyday life,
- the proximity of shops and services, and
- the social aspects, such as the daily communal meal.

Tenants also value having service staff on site 24 hours a day, seven days a week. This increases their sense of security and connectedness (Gnaedinger, 2007). There have been many lessons learned from Fairway Woods. The most outstanding are the following.

- “The location in the suburbs works.”
- It is important to stay small to retain a sense of community and to fit in with a suburban location.
- If the building design facilitates surveillance, there is no need for a security system: the tenants become the security system.
- Staff members’ “unconditional regard” contributes to tenants’ feelings and practice of autonomy.
- “This population can accept each other and build a community” (Gnaedinger, 2007).

Interviews with residents showed similar themes; choice, location, community services (Boydell Consulting Group, 2006).

These principles and the rationales behind them can help order priorities and identify weaknesses in proposed design. Interestingly, these design features corresponded with six valued factors: (1) control; (2) safety/security; (3) accessibility/mobility; (4) function; (5) flexibility; and (6) privacy (Boydell, 2007).

11. Housing Models for People with Fetal Alcohol Spectrum Disorder (FASD)

Program Name	Characteristics	Patient Demographic
Interdependent Living Program Whitecrow Village Society, Nanaimo, BC	GOAL: To establish a permanent home base where adults with FASD can live and work at LIFE sessions or other outside or self-employment. <ul style="list-style-type: none"> • Permanent and satellite housing options (in construction @ time of report) 	<ul style="list-style-type: none"> • Some residents permanent • Others move to satellite housing options or back to community with all having the ability to access continued experiential learning
Residential Program for Male Offenders, Community Support Group Volunteer	Two residential housing projects with support programs	First specialized program focusing on male offenders with FASD

Program, West Coast Genesis Society, New Westminster, BC	<ul style="list-style-type: none"> • Staff connects residents with community employers who provide structure, links and support • Staff remain connected after residents are released from the home • Residents matched with 2-3 volunteers who assist with: shopping, providing emotional support, budgeting 	<ul style="list-style-type: none"> • Male offenders on conditional releases (1 day – 1+ years) • 24 bed facility, with 6 beds for FASD (those with high needs, may have substance use or mental health issues, little family or community supports, find it challenging to live independently)
Ayookhll ga nitx'iitszwim ahl haa' nakthl gabiswit Gitxan Child and Family Services Society (GCFSS) and University of Northern BC (UNBC) Hazelton, BC	<p>Demonstration project – community-based housing for families with FASD (to be built), rooted in the Gitxan cultural tradition</p> <ul style="list-style-type: none"> • Focus on keeping family together while providing them with supported by the resident caregivers. 	<ul style="list-style-type: none"> • Families affected by FASD
FASD Collaborative Family Care Program Prostitutes Empowerment Education Resource Society (PEERS) Victoria, BC	<p>GOAL: To assist mothers with FASD and their children transition to a mainstream lifestyle by providing post-placement support, training in infant development, parenting, lifeskills.</p> <ul style="list-style-type: none"> • 5 care homes 	<ul style="list-style-type: none"> • Mothers with FASD, who have sexually-exploited or have been in the sex-trade • Who are high risk of having their children apprehended and placed with Ministry of Children and Families
Independence for Youth Program Nelson Community Services – Cicada Place, Nelson, BC	<p>Supports provided to residents based on individual's needs and skill sets. Set up as transitional housing, residents can stay longer than two years, if required.</p> <ul style="list-style-type: none"> • 7 – one bedroom units; 3 – two bedroom units • 24/7 resident caretaker • Daily-living skills (shopping, budgeting, employment/ school support, home support skills) 	<ul style="list-style-type: none"> • 16-22 year olds referred by Ministry of Children and Family, Mental Health, schools • Must cook, attend school or work/be actively looking for work
Soaring Eagles Support Services	<ul style="list-style-type: none"> • PDD group home (rural residence for three adult 	<ul style="list-style-type: none"> • Referrals from PDD, court system, RCMP

Whitecourt, AB	<ul style="list-style-type: none"> males, two of whom have FASD) one 3-bedroom basement suite with common kitchen/ living areas Owners live upstairs and provide daily support, with informal support evenings/ weekends Supportive programming includes structure, supervision and resident involvement in shopping, cleaning, recreation, work and/or volunteer programs 	
Bosco Homes Edmonton, AB	<ul style="list-style-type: none"> 48 unit low-income housing project in negotiation with Edmonton Housing Authority to be located either in Edmonton or Wetaskiwin, AB Provides residential resources and mentorship program Youth and mental health programming current located in Wetaskiwin. 	<ul style="list-style-type: none"> Youth requiring extra supports Adults with FASD
Aboriginal Family Services Mentorship Program for Adults with an FASD Supported Housing Project	<ul style="list-style-type: none"> Assists individuals in finding housing Provides assistance for daily living routines 	<ul style="list-style-type: none"> Adults with FASD
Directed Services Model of Resources for Youth and Adults Life's Journey Inc. Winnipeg, MB	<ul style="list-style-type: none"> Interdependent / cluster housing model for youth and adults Fully staffed, 24-7, Four suites in residential building, three supporting by Supportive Living Program (parallel to PDD); one suite for staff who provide on-site support to clients Suites on different floors of building supporting integration 	<ul style="list-style-type: none"> Youth and Adults with FASD High-risk male offenders Must met provincial special needs program criteria (IQ \leq 70), with plan presented/ approved by court

Spectrum Connections	<ul style="list-style-type: none"> • Supports social, financial, emotional and daily living functions • Provides adequate funding to provide care for those requiring transition to adult services. 	<ul style="list-style-type: none"> • 15-18 year olds referred by Child Welfare and Family Service agencies • Youth cannot be eligible for either the two Manitoba provincial programs for those with disabilities
Options for Independence Program Whitehorse, YK	<ul style="list-style-type: none"> • Six-unit buildings owned by Yukon Housing, provides 1-bedroom apartments (five units for client housing, one unit for office) • Residential agreements b/n Society and clients (different from group home or landlord-tenant agreement as staff can enter suites without 24-hour notice) • Security features include: cameras at both entrances, alarms on all ground-level windows, private security company checks when staff not on-site • Clients have support from FASSY (Fetal Alcohol Syndrome Society of the Yukon), for a supported Independent Living Worker • Staff provides advocacy, connections to community resources, allowing for individualized approaches based on client's needs 	<ul style="list-style-type: none"> • Adults with FASD
H.O.M.E.S. (Housing with Outreach, Mobile and Engagement Services)	GOAL: To provide housing choices for those with mental illnesses, a history of	<ul style="list-style-type: none"> • Supports include life-skill training, meal preparation and hands-on planning

Good Shepherd Homes
Hamilton, ON

homelessness, while offering privacy, safety, personal choice and support to achieve personal goals.

- Four buildings with 129 additional suites throughout city
- All units subsidized based on resident's income levels
- Multi-disciplinary team model providing support in advocacy, crisis intervention, problem-solving
- 24-hour support on site with access to holistic nutritionist, R.N., vocational support workers and in some units, recreational support worker
- Mobile support and after hours, on-call support

Source: Burns (March 2008)

12. Intervention for Homeless Persons with Substance Abuse and Mental Illness

Essential Service System Components

Evidence-Based and Promising Practices
Outreach and Engagement <ol style="list-style-type: none"> 1. Meets immediate and basic needs for food, clothing and shelter 2. Non-threatening, flexible approach to engage and connect people to needed services
Housing with Appropriate Supports <ol style="list-style-type: none"> 1. Includes a range of options from transitional and low-barrier housing to permanent supported housing 2. Combines affordable, independent housing with flexible, support services
Multidisciplinary Treatment Teams/Intensive Case Management <ol style="list-style-type: none"> 1. Provides or arranges for an individual's clinical, housing and other rehabilitation needs 2. Features low case loads (10-15:1) and 24-hr service availability
Integrated Treatment for Concurrent Disorders <ol style="list-style-type: none"> 1. Features coordinated clinical treatment or both mental illness and substance use disorders. 2. Reduces alcohol and drug use, homelessness and the severity of mental health problems.
Motivational Interventions <ol style="list-style-type: none"> 1. Helps prepare individuals for active treatment; incorporates relapse prevention strategies 2. Must be matched to an individual's stage of recovery
Modified Therapeutic Communities <ol style="list-style-type: none"> 1. Views the community as the therapeutic method for recovery from substance abuse. 2. Have been successfully adapted for people with SAMI who are homeless
Self-Help Programs <ol style="list-style-type: none"> 1. Often includes the 12-step method, with a focus on personal responsibility 2. May provide an important source of support for homeless people
Involvement of Consumers and Recovering Persons <ol style="list-style-type: none"> 1. Can serve as positive role models, help reduce stigma and make good team members 2. Should be actively involved in the planning and delivery of services
Other Essential Services
Primary Health Care <ol style="list-style-type: none"> 1. Includes outreach and case management to provide access to a range of comprehensive health services
Mental Health and Substance Abuse Treatment <ol style="list-style-type: none"> 2. Provides access to a full range of outpatient and inpatient services (i.e. counseling, detox, self-help, peer support)
Psychosocial Rehabilitation <ol style="list-style-type: none"> 3. Helps individuals recover functioning and integrate into their communities by addressing four key components: employment, education, basic living skills and leisure, which are essential services to prevent isolation and loneliness.

Income Support and Entitlement Assistance
4. Outreach and case management to help people obtain, maintain and manage their benefits
Employment, Education and Training
5. Requires assessment, case management, housing, support services, job training and placement, and follow-up
Services for Marginalized Groups within the SAMI Population
6. Programs focusing on the specific needs of women and Aboriginal people (i.e. trauma, parenting, domestic violence, etc)
Low Barrier Services
7. Helps engage individuals who are initially are unwilling or unable to engage in more formal treatment.
Crisis Care
8. Responds quickly with services needed to avoid hospitalization and homelessness
Family Self-Help/Advocacy
9. Helps families cope with family members' illnesses and addictions to prevent homelessness
Cultural Competencies
10. Accepts differences, recognizes strengths, and respects choices through culturally adaptive services.
Criminal Justice System Initiatives
11. Features diversion, treatment, and re-entry strategies to help remain in or re-enter the community.

Source: Patterson et al. (2008)

13. Support for homeless persons with pets

Dogs Trust Hope Project

The Homeless Link describes the Dogs Trust Hope Project which is a UK scheme which was established in 1994 with a main focus of supporting dogs whose owners are homeless or in housing crisis. The project offers the following major services:

- a) Veterinary Card Scheme
Accessed through homelessness projects, the card entitles the pet owner to preventative services (i.e. vaccinations, neutering, worming and flea treatment) and subsidized veterinary treatment.
- b) Pet Care Advice
Advice is available on most pet owner issues including dog-friendly accommodation, as well as welfare and veterinary issues.
- c) Outreach Services
This project also provides Christmas Outreach Services for dog-friendly projects.

Shelter Space for Companion Animals

Labreque and Walsh (2011) highlighted two shelters in Canada which provide shelter space for their clients' companion animals.

1) Halifax

This shelter provides outdoor kennels for their clients' dogs and some cats. Their choice to keep the pets outdoors was to mitigate any potential allergic reactions should pets remain indoors.

There is no maximum length of stay, as long as the pets are well cared for by their owners and is a strategy used by this shelter to encourage youth to stay at the shelter instead of sleeping rough on the street.

2) Vancouver

The Vancouver shelter has housed pets since 2004. With this model, pets are allowed in the shelter and stay with the homeless in their rooms. They are also allowed to roam free on one of the floors to also benefit the other residents who are without a pet. One floor is designated to remain pet-free for residents who do have allergies or are fearful of pets.

As this shelter has limited available space, the size of the pets permitted into the shelter is restricted to small dogs and cats. Many residents also have birds, rabbits and fish.

Pet care is the primary responsibility of the owners. For those who are struggling financially to keep their pets, the shelter often assists them in finding free pet food and health care through local non-profit agencies.

Doney Veterinarian Clinic

In their research, Ptak (1995) described the services provided by The Doney Veterinarian Clinic, located in Seattle, WA. Since 1989, the group of veterinarians have provided services to pets of the homeless. They adopted and had taken over this model after the death of Stan Coe, Veterinarian and Owner of The Elliott Bay Animal Hospital, who originated this work. The Doney works through the local Union Gospel Mission to provide veterinary services twice per month. Services include: vaccinations, flea allergies, skin problems and digestive disorders. For more serious issues, such as surgeries, pets will be cared for at the Elliott Bay Animal hospital. The veterinarians and staff volunteer their time, while animal pharmaceutical companies and individuals often donate the needed supplies.

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