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A thesis submitted in partial fulfillment of the requirements for the Master of Arts degree in Geography

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Evolution Towards "Housing First":
A Qualitative Analysis of Service Provider and Participant Perspectives

(Thesis Format: Monograph)

By

James Kennedy

Graduate Program in Geography

A thesis submitted in partial fulfillment

of the requirements for the Degree of

Master of Arts

The School of Graduate and Postdoctoral Studies

Western University

London, Ontario, Canada

Abstract

Over the past decade, "Housing First" has gained momentum as an approach to address the needs of individuals facing homelessness. More recently adopted within the Canadian context, Housing First has received considerable praise for effectively housing the chronically and episodically homeless, by getting them off the streets and out of emergency shelters. While the increased adoption of Housing First within the homeless sector in Canada has been backed by evidence-based research, qualitative studies regarding the perceptions of front-line service providers towards Housing First are limited. Using qualitative methods, in-depth interviews and focus group discussions were conducted with service providers and program participants from three separate Housing First programs in Southern Ontario. The data was analyzed to develop key themes surrounding the effective implementation and operation of Housing First programs. The results shows that while service providers and participants believe that, overall, Housing First is the best approach to housing the chronically and episodically homeless, criticisms and challenges of the approach still exist. The findings call for the increased funding by all levels of government towards the development of new affordable housing stock as well as the importance of building strong relationships with housing providers and other non-profit agencies for the continued success of Housing First Programs.

Keywords: Housing First, Treatment First, Supported Housing, Housing and Supports, Assertive Community Treatment, Intensive Case Management, Homelessness, Mental Health, Addictions, Affordable Housing, Municipalities, Ontario

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List of Abbreviations

ACT = Assertive Community Treatment

AH/CS = At Home / Chez Soi

H2H = Hostels to Homes

HF = Housing First

HPS = Homeless Partnering Strategy

ICM = Intensive Case Management

LC = London CAReS

LHRI = Lawson Health Research Institute

MHCC = Mental Health Commission of Canada

SHOW = Supported Housing of Waterloo

T2H = Transitions to Homes

TF = Treatment First

CHAPTER 1

INTRODUCTION AND CHAPTER OUTLINE

1.1 Background

In 2013 the Canadian Federal government announced in their Economic Action Plan that it would renew its commitment to the Homelessness Partnering Strategy (HPS) by refocusing using Housing First as its primary approach to supporting homeless individuals. Under this mandate, $600 million will be invested in order to update the existing structure of homelessness supports in 61 designated communities across Canada and developing local initiatives surrounding Housing First (Employment and Social Development Canada, 2015). The implementation of Housing First as a means of addressing homelessness is primarily aimed at those regarded as chronically or episodically homeless in Canada. The renewed commitment to Housing First under the HPS is based on findings from the Mental Health Commission of Canada's At Home/Chez Soi research project. This 5-year, government-funded project ended in March of 2013 and provided evidence for an increased implementation of Housing First programming across Canada (Goering et al., 2014).

It is estimated that 200,000 Canadians access a variety of homeless emergency services each year (Gaetz et al., 2013). Furthermore, another 3 million are considered "at-risk of homelessness" and live in inadequate or crowded housing or live with relatives or friends (Trypuc & Robinson, 2009). Many of those 3 million individuals, while not

currently accessing emergency shelter services or housing supports, are at high risk of potentially needing additional supports in order to remain housed in the near future. Of the 200,000 Canadians who access homeless emergency services, those considered chronically or episodically homeless may only represent a small proportion of the overall homeless population but they use a disproportionately high amount of emergency support services and funding (Aubry et al., 2013; Kuhn & Culhane, 1998; Kertesz et al., 2005; Gaetz, 2012). One of the major pillars of the Housing First approach is it seeks to provide adequate and suitable housing for the chronically and episodically homeless by integrating affordable housing with individualized and consumer driven supports.

Past approaches to supportive services have been referred to variously as the continuum of care model, the linear model, and the Treatment First approach. While these approaches may have similar mandates, the choice of wording or labeling is used interchangeably and will be discussed further in Chapter 2. In many instances, these past approaches failed to adequately house many of the most intense users of services -due to their higher prevalence of addictions and mental health concerns (Clark & Rich, 2003; Hurlburt, Wood and Hough, 1996; Rosenheck et al., 2003). The challenge of housing someone with addictions or those who suffer from a range of mental health diagnoses is that these conditions can lead to housing instability and poor housing retention rates, potentially leading to individuals reinstating their transient lifestyle of ‘living rough’ and acute stays in emergency shelters (Kertesz et al., 2003).

Housing instability is not a result of a simple cause and effect relationship for the individual and for one specific reason, such as addictions or mental instability. Rather, it is often the “culmination of various underlying and intersecting issues, ranging from

mental health and addiction issues to domestic abuse and poverty" (Turner, 2014, p.1). Equipping individuals with a stable and suitable home with the needed consumer-based supports, through assertive community treatment (ACT) or intensive case management (ICM), can lead to higher housing retention rates and increases in outpatient service use. These solutions are much less expensive for taxpayers as opposed to relying on services provided by departments such as policing or emergency medical services (Banks et al., 1999; Dharwadkar, 1994; Lehman et al., 1997; Lehman et al., 1999). In a 2013 report titled, "The State of Homelessness is Canada 2013" it was estimated that the annual cost of managing homelessness through emergency responses such as policing, emergency medical services and shelters is over $7 billion (Gaetz et al., 2013). Reducing the use of emergency services could drastically decrease the cost associated with addressing homelessness for the most intense users. One way of doing this is to keep individuals housed and to provide outpatient services to meet their needs. In one study comparing 5 Canadian cities using Housing First the authors found that after a one-year-follow up, 73% of those using a Housing First approach were still stably housed compared to 37% of those still using treatment to which they had become accustomed (Aubry et al., 2015).

Proponents of the Housing First philosophy believe that housing should be a basic human right and that a stable home can create the foundation on which the process of recovery and reintegration can begin (Tsemberis, Gulcur & Nakae, 2004; Turner, 2014). Understanding the challenges faced by those who work with this approach on a daily basis is needed in order to eliminate some of the disconnect between policy makers and front-line staff.

1.2 Purpose of the study

Due to its increasing adoption, Housing First has attracted a range of scholarly work (Cohen, 2008; Goering et al., 2014; Gulcur et al., 2003; Henwood et al., 2013; Hwang et al., 2012; Padgett et al., 2011). Much of the current research focuses on quantitative aspects of the Housing First approach, such as: length of housing retention (Stefancic & Tsemberis, 2007; Aubry et al., 2015), reductions in social spending (ONPHA, 2013, Gaetz et al., 2013), and reductions in drug and alcohol use (Padgett, et al. 2011). While these are all important markers of success, the aforementioned assessments focus mainly on the quantitative aspects related to Housing First program participants.

The majority of studies have focused on treatment and housing outcomes of the participants of Housing First programs. Despite the importance of the experiences and opinions of different Housing First participants in the context of each individual program to achieve an understanding of the effectiveness of Housing First, few studies, with the exception of Henwood et al., (2013) who looked at the Pathways to Housing First in New York and Nelson et al. (2013), have taken this approach.

Some implementation and fidelity evaluation studies of At Home/Chez Soi programs, discussed further in Chapter 2, have explored the perceptions of front-line staff towards Housing First in Canada.

There is a gap in the literature understanding and documenting the concerns and experiences of those who work at the front-line and on a daily basis with Housing First programming, outside of the two major programs mentioned above, can address this gap in the research.

Although participant perceptions can provide insight into the successes and disadvantages based on the first-hand experience with Housing First programming, they lack a structural and systems understanding of the specific markers to success pertaining to the implementation and daily operation of Housing First.

Service providers can lend a wealth of knowledge and experience in order to strengthen or address any potential weaknesses associated with the Housing First approach and philosophy.

In order to address the needs of the most chronically and episodically homeless in many Canadian communities, understanding the perceptions of service providers towards the changing structure of homeless supportive services can bridge the gap between policy makers and service providers.

In addition, by looking at qualitative data collected from Housing First participants, comparisons in the findings can be made so that the needs of participants are more effectively met.

1.3 Research Questions

Two chapters in this dissertation (i.e. Chapters 4 and 5) contain findings about a broad set of factors that influence the operation of the Housing First model as an approach to dealing with homelessness.

A consideration of both service providers and program participants allowed me to synthesize a holistic explanation of the strengths and weaknesses of the model.

The research questions guiding this study are:

(1) Do service providers consider the Housing First philosophy and the way it is

organized as the most effective approach to housing the chronically and episodically homeless?

(2) Which aspects of this "new" model do service providers see as strengthening supportive services?

(3) Based on the perspectives of service providers, what are the major barriers to the effective operation of the Housing First model?

(4) What are the thoughts of program participants about Housing First?

and

(5) What recommendations do service providers have for the improvement of Housing First programming?

These questions emanate from the need for further understanding of the operation and implementation of the Housing First Model in order to continue the discussion of the most effective means to address the issue of homelessness.

To answer the above questions, this research will focus on the following specific objectives:

1. Examine the perceptions of service providers on the major barriers to the successful implementation and operation of Housing First supportive services.
2. Investigate service provider and program participant perspectives on the benefits and limitations of Housing First approaches.
3. Assess the extent to which service providers agree that Housing First is the most effective approach to provide housing and supports for the chronically and episodically homeless.

Overall, this thesis seeks to understand the perceptions of service providers working with the most recent form of providing housing and supports to homeless individuals. Housing First is situated in a realm of prior experiences with the old Treatment First model, as well as engaging with other community partners whose service-orientation still reflects the traditional approach to supportive housing (Henwood et al., 2013).

This thesis is based on in-depth interviews (n=10), and focus group discussion (n=12) with service providers in three Southern Ontario cities, namely London, Hamilton, and Waterloo. Additionally, this thesis draws on interviews with sixty-five (n=65) participants from the City of London. Comparisons with the perceptions of service provider's experiences of the program to the experiences of the participants of the program will be made as a means of addressing the limitations in the literature up to the present.

1.4 Outline of the Thesis

The body of this thesis is augmented by 5 additional chapters.

Chapter 2 provides an overview of homelessness in Canada as well as outlining the new and pre-existing approaches to supportive and supported housing. The chapter starts by defining homelessness and establishing a theoretical understanding of the different categories of homelessness from which supportive services and housing supports can be understood. It also discusses some of the costs associated with the transient lifestyle of homelessness and the misuse of municipal and provincial emergency services. This

chapter also provides a framework for understanding the different forms of housing and supports as well as outlining the core principals of those different approaches. It also outlines the "best-practice" approaches to Housing First and looks at studies detailing their successes and shortcomings as programs. This chapter concludes by comparing the more longstanding and commonly used Treatment First or linear approaches to supportive housing to the new, government favoured, Housing First approach. Outlining outcomes such as housing retention, drug and alcohol dependence, emergency service usage and consumer led rehabilitation and community integration.

Chapter 3 describes the rationale for the use of qualitative research techniques as the means of data collection, analysis and reporting. More specifically, it outlines the different techniques and approaches in interviewing service providers and tenants as well as the rationale for the inclusion of a focus group discussion in this study. The chapter goes on to outline some of the coding and analysis techniques used in the interpretation of data as well as the ways in which rigour was achieved. Finally, this chapter discusses some ethical considerations involved with data collected from at-risk populations as well as looking at some of the limitations of the study.

The findings of the study are separated into two chapters (Chapters 4 and 5). Chapter 4 looks at the perceptions of service providers towards the changing environment of supportive services and some of their thoughts on the ease of this transition. This chapter first outlines some of the more specific factors that were addressed by service providers, which they believed, inhibited or suppressed the effectiveness of Housing First as both a paradigm and as a program. The chapter finishes by encapsulating the overarching perspectives of service providers towards their program and its approach to the Housing

First model as well as whether or not they believe Housing First is the best means of addressing challenges faced by homeless persons.

Outlining the perspectives of service providers gives the backdrop for Chapter 5, which summarizes the standpoint of program participants towards Housing First. This chapter examines participants' perceived health and housing outcomes, before and after involvement with Housing First. The chapter also documents participants' positive and negative experiences engaging with service providers, including what they regard as the most important aspect of those relationships, as well as perceptions of the Housing First framework or model.

In Chapter 6 comparisons of the similarities and differences in the findings from service providers and participants will be made in order to lead to more effective supportive services and housing outcomes for homeless individuals. This chapter further provides an overview of major themes and trends, recommendations for future developments in services, as well as contributions to the research and concludes with remarks regarding the current state of supportive services.

The information found in chapter 4 and 5, as well as information collected from Chapter 2 provide an outlet for a more comprehensive and detailed analysis of the common themes that were addressed in this study, which in effect, lead to structural and organizational changes within these programs and lead to policy changes for the communities involved. The findings may also provide insight into the challenges regarding the structure of housing and supports in cities not only within Ontario, but Canada and abroad.

CHAPTER 2

LITERATURE REVIEW: HOMELESSNESS AND HOUSING FIRST

2.1 Introduction

Understanding the needs and causes of someone who is considered homeless can be a very complex and taxing endeavour. The constantly changing economic and political climate at the three levels of government in Canada, including the funding structures and policies to tackle homelessness, has influence on how homeless persons are defined as well as determining the best approaches to dealing with issues surrounding homelessness. Changes to homelessness support services have gained serious media and policy attention in recent years. Specifically, Housing First (HF), the newest evolution of supported housing within the homeless social service sector, has received tremendous attention.

This Chapter reviews the HF philosophy and the program model as a potential solution to homelessness. Prior to the review, the Chapter defines homelessness and conceptualizes the many facets of how an individual might become homeless, or be at-risk of homelessness. An understanding of the factors related to how someone becomes and stays homeless is used as a lens through which to analyze housing support programs currently in use.

2.2 Defining Homelessness

In practice, as well as in theory, a concise definition of homeless and homelessness has often proved a difficult task. While there are no universally shared definitions, there are multiple viewpoints about what constitutes homelessness. For instance, the United Nations (2009) and the Conference of European Statisticians (CES) categorises people experiencing homelessness into two broad categories: primary and secondary. Under the primary category, homelessness or "rooflessness" is regarded as persons living in the street without shelter. The secondary category includes "persons with no place of usual residence who move frequently between various types of accommodations (including dwellings, shelters and institutions for the homeless or other living quarters). This category also includes persons living in private dwellings but reporting 'no usual address' on their census form" (U.N., 2009, p.3). Although the above definition appears wide-ranging, such conceptualization has been criticized as too narrow for understanding the complex situation faced by homeless individuals (Gaetz et al., 2013).

Another definition provided by the Canadian Homelessness Research Network (CHRN, 2012, p.1), which addresses the causes and barriers faced by homeless individuals, defines homelessness as:

> "The situation of an individual or family without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it. It is the result of systemic or societal barriers, a lack of affordable housing and appropriate housing, the individual/household's financial, mental, cognitive, behavioural or physical challenges, and/or racism and discrimination. Most people do not choose

to be homeless, and the experience is generally negative, unpleasant, stressful and distressing."

The CHRN's definition provides a multifaceted look at the effects, challenges and consequences facing homeless individuals. It also shows the complicated nature of defining homelessness as it can be seen more as an umbrella term in which a range of individuals with different socio-economic backgrounds, religious or cultural groups, age or gender may belong. As with defining homelessness, characterizing those who are homeless, where they reside and for how long, can be challenging.

In their paper "The State of Homelessness in Canada 2013" Gaetz et al. (2013, p. 13) include a range of housing and shelter circumstances a homeless individual may experience:

1. *Unsheltered*: or absolutely homeless and living on the streets or in places not intended for human habitation, such as people living in public or private spaces without consent or contract, or people living in places not intended for permanent residence or habitation.
2. *Emergency sheltered:* includes those staying in homeless shelters, shelters for those impacted by family violence, as well as those fleeing a natural disaster or destruction of accommodation.
3. *Provisionally accommodated:* refers to those whose accommodation is temporary or lacks security of tenure. This includes people either staying in interim or transitional housing, living temporarily with others (i.e. couch surfing), accessing short term, temporary accommodation (i.e. hotels and motels), or living in

institutional contexts (i.e. hospitals, prisons) without permanent housing arrangements.

4. *At risk of homelessness:* refers to people who are not yet homeless but whose housing and/or economic situation is unstable or does not meet public health and safety standards. This category is included due to the fact that homelessness is considered a fluid experience where one's shelter circumstances and options shift and change frequently.

One thing that is apparent about homelessness in Canada and elsewhere is that it is near impossible to determine the exact numbers of homelessness in a defined geographical unit. This is due to lack of a consistent definition (as shown above), the fluidity of those involved, and a lack of point in time counts of sheltered and unsheltered homeless persons (Gaetz, Guilliver, & Richter, 2014).

Trypuc and Robinson (2009) focus on the absolute homeless or those characterized as having no housing, and are "roughing it" on the streets, or who frequent the shelter system. Specifically, the authors point out that homelessness includes those "who live in inadequate or crowded housing, or the invisible homeless who are "couch surfing" or sleeping with friends" (Trypuc & Robinson, 2009, p.5). Using this definition, the authors determine the number of absolute homeless to be approximately 157,000 people in Canada. It is estimated that the number of people living in poverty who may benefit from social assistance, housing improvements, or low-cost housing could be upwards of 3.2 million Canadians (Statistics Canada, 2009)

While the above statistics seem staggering, the estimates only provide an approximation of annual encounters within emergency shelter services. Gaetz, Guilliver

and Richter (2014) estimate that at least 235,000 Canadian's access homeless emergency services or sleep outside each year. As well, the number of Canadians who experience homelessness on any given night is estimated to be approximately 35,000 individuals. This number was determined based on three categories of homelessness: those who are unsheltered, those staying in emergency shelters, or those considered provisionally accommodated (Figure 2.1).

Figure 2.1: Homelessness in Canada

Gaetz, Gulliver, & Richter, 2014, p.5

While this is not an absolute number for homelessness in the country, the author cautions the quoting of this figure as Canada does not conduct coordinated point-in-time counts on any given night of the homeless population, making it difficult to calculate exact figures (Gaetz, Gulliver, & Richter, 2014). Many of the individuals included in this estimation also frequent the emergency shelter system and may access services upwards of 200 nights a year. Social service agencies providing support to the homeless, such as

emergency shelters and hostels, can determine the numbers of individuals who use their programs quite easily, due to the collection of personal information into some form of database upon admission to shelters and hostels.

Correctly identifying an individual as homeless can be challenging, as not all those who experience homelessness appear to be homeless, nor do they congregate in expected locations throughout the city (Wright, Rubin, & Devine, 1998). To reiterate, another difficulty is the variance in the definition of homelessness across Canada leading to differences in measurements and indicators, causing variation in figures of homelessness from each municipality (Gaetz et al., 2013). While the aforementioned challenges in determining exact numbers of homeless populations in different municipalities exists, the annual and daily estimates provided, still give government and non-profit agencies, their staff, and social service advocates, an idea of how local and regional approaches are doing in putting an end to homelessness.

2.2.1 Categories of Homelessness—Transitionally, Episodically, Chronically

In order to better understand some of the theoretical issues and costs associated with homelessness, the typology of homeless shelter users will be outlined. Kuhn and Culhane (1998) developed a typology to describe shelter stays amongst the homeless population. The typology has been used in describing the use of shelters (Gaetz et al. 2013; Gaetz, Scott, & Gulliver, 2013; Layton, 2008; Metaux et al., 2001), the decline in health outcomes (Kertesz et al., 2005; Hwang, 2001; Hwang et al., 2012; Frankish et al., 2005) and cost benefit analyses (Gaetz, 2012; Gaetz et al, 2013; Gaetz, Gulliver, & Richter, 2014). Overall, the median length of stay in shelters is 50 days, although most homeless people stay for less than a month and generally manage to become housed on

their own, in fact 24-29% stay only one night (Segaert, 2012, p.19). There are three broad categories of homelessness: transitional, episodic, and chronic.

The 'Transitionally homeless' category involves individuals and families who have relatively short stays in the shelter system, and who tend to not return. These individuals have had crises due to circumstantial issues such as a loss of job, loss of housing, or other temporary conditions that have resulted in them not having a place to live. They tend to be younger and less likely to have complex issues related to mental health, addictions, and other health related issues (Gaetz et al., 2013). Very often this is the result of limited affordable housing, having a house that they could afford and/or having had difficulty finding another location within their budget. However, once sheltered and allowed to recuperate they are able to regain housing with little difficulty (Metaux et al, 2001). In Canada, the transitionally homeless category makes up between 88-94% of the homeless population (Aubry et al., 2013).

The 'Episodically homeless' segment includes individuals who use shelters intermittently, moving in and out of homelessness several times over a three-year period. Some of these moves may include corrections facilities or short term stays in hospitals (Gaetz et al., 2013). Generally these individuals have more complex issues than the transitionally homeless and represent about 9% of the homeless population. In Canada, episodic homeless numbers range from 3-11% (Aubry et al., 2013). In their study, Kuhn and Culhane (1998) found that this population had around 5 different periods of homelessness over three years, and spent approximately 264 nights in shelters.

The 'Chronically homeless' group is the population that has the most impact on the emergency support system as these individuals are long-term shelter users. These

individuals spend long periods of time within the shelter system or live on the streets. Kertesz et al. (2005, p.577) defines chronic homelessness as an ‘unaccompanied single adult with a disabling condition, which may include addiction, who has experienced homelessness continuously for a year or more, or 4 times during a period of 3 years’. The majority have serious mental or physical health problems or addiction issues. In the U.S. study by Kuhn and Culhane (1998) they found that the chronically homeless represented 9.8% of the homeless population and although they only averaged 2.3 stays over 3 years, it was for long periods of time, ranging from 317 to 1095 days in shelter, per stay. In Canada the chronically homeless population was found to be smaller, representing 2 to 4 % of the overall population (Aubry et al., 2013).

While the number of episodically and chronically homeless individuals is relatively small, these two clusters are the highest users of homeless services. For instance, in Toronto and Ottawa, the episodic and chronic homeless populations occupied over half of the shelter beds, although they represented only between 12 per cent and 13 per cent of the shelter population” (Aubry et al., 2013, p.5). In their most recent report, “The State of Homelessness in Canada 2014”, Gaetz, Gulliver and Richter (2014) found that the number of episodically and chronically homeless in Canada was between 13,000 and 33,000 individuals. Those who are chronically homeless generally suffer greater deterioration of health and as a result are more frequent and intense users of health services (Gaetz, 2012).

2.2.2 Understanding Homelessness: some theoretical issues

Homelessness has been attributed to several broad and specific causes. The theoretical explanations of homelessness are well established in the literature so only a brief description is provided in this sub-section.

In general, homelessness has theoretically been attributed to two broad causes, structural and individual.

Structural factors are generally social or political/economic in nature and exist outside of the control of the individual. They may include things such as increased poverty and unemployment, declining availability of affordable housing, inadequate social assistance benefits, the reduction in psychiatric beds, an overall weakening welfare state, globalization and economic restructuring and gentrification (Daly 1996; Favlo, 2009; Gaetz, 2010; Turner, 2014; Shinn, 2007, Kuappi & Braedley, 2003).

Individual risk factors are variables that have altered the lives of the individual due to choices made by themselves or those of close family and friends. It emphasizes the role that individual pathology and disability play in the process of homelessness. Causes include challenges such as mental illness, drug and alcohol addiction, physical or mental abuse, involvement with crime, lack of job skills, and individual debt (Falvo, 2009; Zugazaga, 2004; Sullivan, Burnham, & Koegel, 2000; Kim et al., 2010).

Gaetz et al. (2013) also attribute '*system failures'* as another reason why individuals end up homeless. 'System failures' refers to a lack of adequate support from pre-existing social service agencies or other mainstream avenues for care. These agencies failed to adequately support at risk individuals, which in turn, compels them to resort to accessing the homelessness services. System failures include "difficult transitions from

child welfare, inadequate discharge planning for people leaving hospitals, corrections and mental health and addictions facilities and a lack of supports for immigrants and refugees" (Gaetz et al. 2013, p.13). All of these causes can individually or collectively lead to an individual becoming a "homeless" person. Table 2.1 summarizes these factors.

Table 2.1: Causes of Homelessness

Causes of Homelessness	Examples
Structural Causes	- Unemployment - Lack of affordable housing - Inadequate social assistance benefits - Reductions in the number of psychiatric beds - Weakening welfare state - Globalization and economic restructuring - Gentrification
Individual Risk Factors	- Physical disability - Mental or physical illness - Social disaffiliation (e.g. personal choice) - Deviance from Societal norms (e.g. drugs and alcohol addiction, juvenile delinquency, criminal behaviour) - Physical and/or mental abuse - Human capital deficit (e.g. low or no education, lack of job skills and work experience) - Individual debt
System Failures	- Difficult transition from child welfare - Inadequate discharge planning from hospitals, corrections, mental health and addictions facilities - Lack of supports for immigrants and refugees

While most people enter the low-income bracket at some point in their lives (such as students, those learning a trade and individuals who are retired or unemployed) most do not remain there for extended periods of time (Urmetzer & Guppy, 2009). Those who are permanent occupants of the lowest brackets, such as those experiencing consistent homelessness, can sometimes be caught in a cycle of homelessness, trapped due to one or more of the specific factors mentioned above. For example a large proportion of individuals who experience homelessness have serious mental illnesses (Lowe and Gibson, 2011; Rickards et al., 2010) and while mental illness is a risk factor for homelessness, the experience of homelessness is also a risk factor for developing a serious mental illness (Bhugra, 2007).

2.2.3 The Issue of Affordable Housing

Not only are some Canadians finding it more difficult to find work providing a decent wage in order to obtain the basic necessities of life, such as food, clothing and transportation, but it has also become increasingly more difficult to find affordable housing. “Affordable housing” in Canada is defined as “permanent housing that costs less than 30% of total household income for low- to moderate- income Canadians” (Gaetz, Gulliver & Richter, 2014, p.22). The importance of not exceeding 30% of total household income is so that families can also afford other daily necessities such as food, transportation, utility payments and clothing.

One of the main reasons for the decrease in affordable housing availability involves the dismantling in the 1980’s of Canada’s national housing strategy (Gaetz et al., 2013; Mah, 2009; Pierre, 2007; DeJong, 2004). Leone and Carroll (2010) attribute the increasing lack of affordable housing to changes during this time when Canada

experienced unparalleled economic growth and as a result felt that housing was not a priority. Individuals who had core housing needs found themselves on the street despite the wealth that was created by the overall economy. This set the groundwork for a crisis in housing to emerge where growth in demand far outstripped supply. The decentralization of housing policy by the federal government reinforced the perception that housing policy should not move forward with federal leadership. Initially, housing policy shifted to the provinces, which was then moved to municipalities, the private sector, and various forms of community partnership through nongovernmental organizations or other civil society groups. This left the policy area surrounding housing in utter confusion (Leone & Carroll, 2010).

Federal and provincial government retrenchment in the 1980s and 1990s and the overall decline in the social housing sector also contributed to the decrease in public rental housing production (Walks, 2006). The reduction in spending towards social and affordable housing began in the 1980's and continued until 1993 when the federal government ceased its investment in new housing stock (Gaetz, 2010). Traditionally, most affordable rental housing built in Canada had been constructed with government subsidies and reduced spending severely affected the new supply of affordable rental housing and social housing (Mah, 2009). This lack of funding led to a shift of housing production and supply in the Canadian market to the free market (Walks, 2006) as well as a change of priorities toward incentivizing home ownership (Gaetz, Gulliver, & Richter 2014). The downloading of fiscal and managerial responsibilities from the federal government to the provinces and municipalities has forced many non-profit cooperative groups to find innovative ways of providing affordable housing to low-income residents

without being able to rely on government assistance and subsides to survive (Pierre, 2007). Also, many municipalities are forced to find creative ways of instituting methods of ensuring affordable housing provision which fall within the confines of municipal budgets (De Jong, 2004). Federal funding aimed towards augmenting affordable and social housing stock has increased from 1993 levels with the new "Investment in Affordable Housing" agreement. Initially announced in 2011, federal and provincial governments have agreed to fund new investment until 2019 but policing or regulation is needed in order to make sure those investments address individuals experiencing homelessness (Londerville and Steele, 2014).

2.2.4 The Cost of Homelessness

Providing services for homeless families and individuals is an expensive endeavour. In 2009, it was estimated that approximately 498 shelters exist across Canada totalling 17, 256 beds. Of those, about 31% (5,349 beds) were in the province of Ontario (Hwang et al., 2012). The costs of shelter services vary across communities in Canada. For instance, Shapcott (2007) calculated the average monthly cost for shelter services in Toronto to be approximately $1,932 per person. As a comparison, Shapcott looked at other monthly costs associated with homeless persons including: hospital bed use, $10,900; provincial jail, $4,333; and social housing, $199.92. In British Colombia, the estimated cost was $24,017, per person annually (Eberle et al., 2001). This figure includes services such as using jails, ambulances, social services, health care, and hospital admittance. Estimates in the City of Calgary put the average annual cost of the chronically homeless at about $105,000 per person (Calgary Committee to End Homelessness, 2008). While these are just a few examples, the variability in findings is

apparent. In a report by Charity Intelligence, they calculate an average dollar amount for each chronically homeless person in Canada. The report took the findings from the BC study mentioned above, as it provided the most detailed breakdown of costs, and added the costs from another study comparing costs in 4 other Canadian cities (Pomeroy, 2005). Based on the numbers they came to a conservative estimate of costs for each chronically homeless person in Canada to be $35,000 (Trypuc & Robinson, 2009).

In the U.S., chronically homeless individuals comprise a small proportion of the overall homeless population (estimates range between 10 to 22%), but they suffer from a disproportionately high level of disability and have been shown to be the most intense users of health care and social services (Kuhn & Culhane, 1998; Kertesz et al., 2005). Another U.S. study (Poulin et al., 2010) found that 20% of the homeless population categorized as chronically homeless account for 60% of the total service costs.

Addressing the issues of homelessness in communities across Canada can provide system wide savings that could boost resources available for other areas of concern within the Canadian economy. When estimating the annual cost of managing homelessness through emergency responses such as policing, emergency medical services and shelters, Gaetz et al. (2013) found that it could cost upwards of $7 billion annually.

Understanding the different causes, categories and costs of homelessness is important as it provides insight into the types of supported housing programs that are offered to help those most severely affected by homelessness. The traditional hallmark of supportive housing programs for dealing with repeated users of emergency shelter services is the ‘linear or treatment first’ approach. While still in use, and still an

important facet of homelessness supportive services, many communities are finding that the newer ‘Housing First’ philosophy provides increased cost savings and reduces the recidivism of individuals accessing emergency services. The recent At Home/Chez Soi final report found that spending $10 on housing and supports for chronically homeless individuals using the Housing First approach resulted in $21.72 in savings related to health care, social supports, housing and involvement in the justice system (Goering et al., 2014).

With many communities already evolving to ‘Housing First’ services and philosophy and government endorsement and funding through the ‘Homeless Partnering Strategy’ the extent of future long-term savings from Housing First has yet to be determined. Our current understanding of the framework and its evolution and adoption as the present approach to homeless housing services as well as how Housing First became such a popular model for government and non-profit agencies will now be discussed.

2.3 Custodial, Supportive and Supported Housing

To best understand the current approaches to housing the chronically homeless, distinctions between custodial, supportive and supported housing programs will be briefly highlighted.

After the deinstitutionalization of the mental health sector in the 1970s, custodial housing became the major form of housing for people with severe and persistent mental illness. This type of housing refers to board and care homes and is often for profit in semi-institutional facilities (Parkinson, Nelson, & Horga, 1999). Due to critiques of segregation, social isolation and dependency created among its residents, (Aubry, Ecker,

& Jette, 2014) supportive housing was offered as a solution in which residents could develop life-skills through community treatment and rehabilitation (Ridgway & Zipple, 1990). Supportive housing became the major form of housing for those facing persistent homelessness. Consumers received shelter and on-site rehabilitation in a group home or clustered apartment with common areas. As their functioning improved, they would move to a less restrictive setting along a continuum (Aubry, Ecker, & Jette, 2014). This approach was the leading program model up until the late 80s and early 90s when supported housing started to become more prominent in homelessness housing programs.

Within supported housing, participants choose, get and keep regular housing in the community. In many cases rent supplements are provided and support is no longer provided at a single site but provided by mobile case manager or service providers who are able to move and meet clients according to their needs and location (Tabol, Drebing, & Rosenheck, 2010). Now, the major approach within the field of mental health, ‘‘supported housing’’, is an approach to meeting the housing and support needs of individuals with psychiatric disabilities that is rooted in core principles of consumer empowerment and community integration (Wong & Solomon, 2010). Supported housing usually involves Assertive Community Treatment (ACT) or Intensive Case Management (ICM) or some similar level of support (Tabol, Drebing, & Rosenheck, 2010). Stable affordable housing with support levels appropriate to an individual’s needs can lessen the debilitating effects of repeated homelessness cycles, improve quality of life, reduce stigma, and in some cases, can enable the individual to recover the ability to live and function independently, even potentially returning to, or entering the labor market which may result in improved productivity and reduced use of social assistance (Pomeroy, 2007,

p.26). In many cases, the term “supportive” and “supported” are used interchangeably when describing housing support programs for homeless participants. In some instances programs may take an integrated approach within the spectrum of supportive and supported housing, using traditional continuum based ideology from “supported housing” while offering consumer choice and self-determination usually found in the newer “supportive programs”.

2.4 Linear Approaches / Treatment First

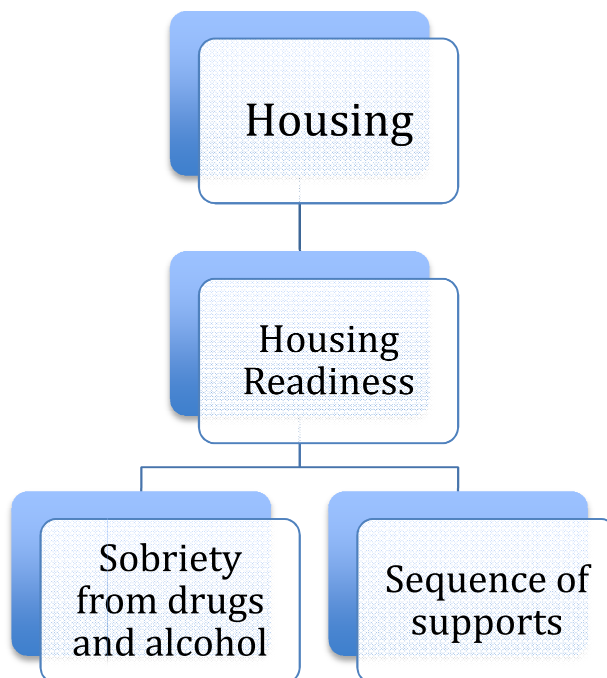
Before looking at the Housing First approach to supported housing, now considered best practice in housing the most chronically homeless (Goering et al., 2014; Gaetz, Gulliver, & Richter, 2014), I will outline some of the more traditional approaches, that have been the hallmark of supportive or supported housing for decades. These linear or traditional approaches sometimes referred to as the continuum-of-care model of supportive housing, assume that a return to long-term stable housing, in either the private market or a subsidized setting, requires the restoration of behavioral norms and the capacity to interact in a constructive social environment. This approach, which will be mainly referred to as the Treatment First approach, recognizes an individual’s tangible resource needs must be addressed in order to ensure that the person’s engagement and attendance in treatment is successful (Sosin, Bruni, & Reidy 1995; Zerger 2002). Traditional models are based on the use of “transitional preparatory settings and mandatory adherence to treatment plans in order to graduate to less-restrictive settings” (Tobol, Drebing, & Rosenheck, 2009, p. 450). In this model clients are expected to transition through a variety of stages and types of housing in order to achieve “housing

readiness". Housing readiness within the Treatment First framework is generally seen as being drug and alcohol free and agreeing to abstain from all substances. When residents in traditional continuum model programs do make progress, they are moved along to a new environment and can lose established social supports, leading to a normalization of residential instability (Blanch, Carling, & Ridgway, 1998).

Throughout the literature, many scholars vary in their understanding of what constitutes Treatment First, as well as the effects it may have on participants. Henwood et al. (2013) see Treatment First providers as often needing to frame their ability to help consumers as an all-or-nothing proposition based on a consumer's ability to conform to program expectations. For many chronically homeless individuals with drug and alcohol problems, Kertesz et al. (2003) believe that repeated contact with traditional medical model approaches may be less successful, and may result in a revolving door of jail, medical detoxification, mandatory abstinence-based treatment programs and failed attempts to navigate continuum-based housing. Hopper et al. (1997, p. 661) expressed similar views stating "the system can contribute to chronic homelessness for many individuals who then join the 'institutional circuit' and rotate through repeated stays in costly acute care services, such as emergency rooms, hospitals, shelters, and jails". Other scholars believe that individuals prefer the relative independent life on the street rather than a fragmented treatment system that inadequately treats multiple diagnoses or addresses housing needs (Amussen et al. 1994; Osher & Drake, 1996). Treatment First approaches believe that clients must first address drug and alcohol abuses, develop sufficient "life skills" and potentially receive counselling for specific mental health concerns before receiving stable, permanent housing. As well, there are generally

individualized requirements that must first be met in order to "earn" the right to stable housing. Figure 2.2 illustrates some of the requirements or steps involved in a participant's path to "earning" housing.

Figure 2.2: The Treatment First Approach



"Housing readiness" is central to the Treatment First framework but without any semblance of stability in an individual's life, which can be provided by housing, many programs find increased rates of recidivism and therefore a loss of funding (Kertesz et al., 2003). While Treatment First programs focus on treatment before graduating to housing, the Housing First philosophy separates treatment from housing and considers treatment voluntary upon a client's readiness to participate, while seeing stable housing, which meets the needs of each individual, to be a fundamental need and human right.

2.5 Housing First

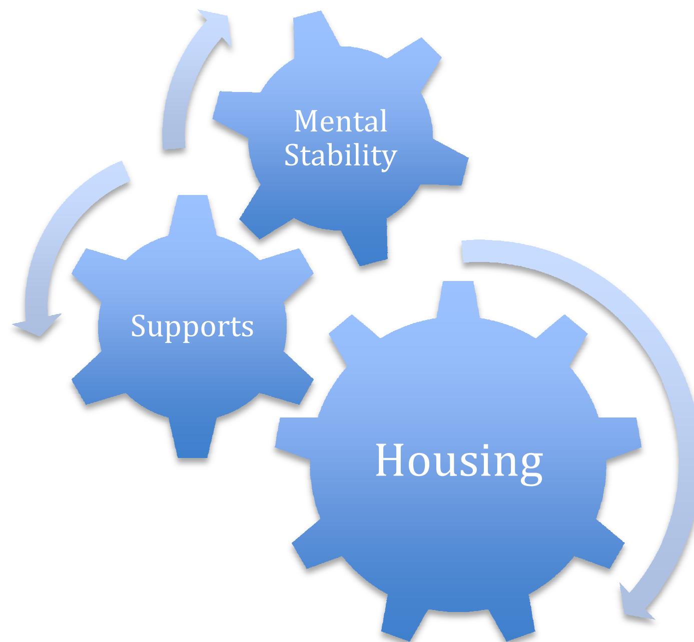
'Housing First' is the concept of helping homeless individuals deal with substance abuse issues or mental health challenges by providing immediate housing along with personalized supports. It centers on the idea that individuals may be more responsive to interventions and supportive services after they have been stably housed, as opposed to receiving supports in temporary or transitional housing facilities or programs (Gaetz, Scott, & Gulliver, 2013). The expression "Housing First" was first used in the U.S. by the National Alliance to End Homelessness in 1999. The aim of Housing First was initially to contact homeless persons in out-reach activities and then offer them permanent housing. The approach was the first to not require a homeless individual's participation in other services as part of gaining access to that housing (Tsemberis & Eisenberg, 2000). The core principles of Housing First involve the following:

1. Immediate access to housing with no housing readiness requirements
2. Consumer choice and self determination
3. A recovery orientated approach (including harm reduction strategies)
4. Individualized and person-driven supports
5. Social and community integration

The Housing First philosophy believes that providing a person with housing, first, creates a foundation on which the process of recovery can begin (Tsemberis, Gulcur, & Nakae, 2004). The key to the success of Housing First programs is by providing stable housing for an individual from the onset of program implementation. By providing individuals with stable housing, it sets the groundwork for successive participation in supportive community services addressing client centered needs such as addictions or

mental health concerns, as is shown in Figure 2.3.

Figure 2.3 The Housing First Approach



Having access to a stable and affordable home is something that many Canadians take for granted. Many people within the homeless community never reach a point of stability at which remaining housed is considered a viable future within the current system. Turner (2014) states that the "stability of a permanent home provides the foundation that allows individuals to begin addressing the issues that led to their housing instability in the first place". Within Housing First, individuals have a choice over their housing and treatment with individualized supports through harm reduction strategies.

'Harm reduction strategies' represent a set of compassionate and pragmatic approaches that aim to minimize harm related to drugs and alcohol use, in order to maximize the quality of life for affected individuals and their communities (Marlett,

1998). This allows for consumer choice not only when it comes to housing but also sobriety and abstinence requirements. Harm reduction focuses on "accepting clients where they're at" (Denning, 2000, p. 4) and when someone is not willing or able to abstain from drugs or alcohol, it may, therefore, be more effective to engage that person in strategies to make their drug and alcohol use safer and more responsible (Miller & Rollnick, 1991). Providing supports for individuals when requested and allowing for consumer choice, allows for a more seamless transition of integration back into the community. The relationship to choice, and housing success over time, indicates that initial choice positively affects housing satisfaction, residential stability, and psychological well-being in Housing First clients (Srebnik et al., 1995).

The 5 core principles of Housing First, mentioned above, provide the ideal framework for an effective program based on best practice, reinforced by studies like At Home/Chez Soi and programs such as the Pathways to Housing First, which will be discussed further in this chapter. Unfortunately research on the implementation of Housing First programs has in fact shown considerable variability in the implementation of core principles (McHugo et al., 2004; Rog & Randolph, 2002; Wong, Filoromo, & Tennille, 2007; Turner, 2014).

Currently in most programs, the target population is chronically homeless individuals; the majority of which are middle-aged men. The broadening of scope beyond this target group to other populations such as; youth, families and women fleeing domestic violence, is an ongoing process and will continue to be explored (Gaetz et al., 2014). Also, in order to outline best practice approaches Housing First, At Home/Chez Soi and Pathways Housing First models will be explored. In addition, to better

understand the two models, I will first explain the importance of Assertive Community Treatment (ACT) and Intensive Case Management (ICM) teams and the role they play in the effective implementation and operation of Housing First programs.

2.5.1 Assertive Community Treatment (ACT) and Intensive Case Management (ICM)

Among other things, supportive services include "intensive case management, moderate case management, custodial care, mental and physical health care, treatment for addiction and substance use, income enhancement, housing assistance, and many other social services" (Cohen, 2008, p. 32). Supportive services are usually provided in a multidisciplinary approach such as Assertive Community Treatment (ACT) or Intensive Case Management (ICM) teams. The teams are generally located off site where someone is available 24 hours a day, seven days a week, to provide services to the consumer in their natural environment, such as an individual's apartment, workplace, or neighborhood. Within Housing First, services continue for every individual as long as the participant desires the given level of support (Tsemberis, 2010). Those with moderate needs generally utilize ICM and those with the highest needs generally utilize ACT teams. ICM is a team model in which "caseworkers, working alone or in teams, link clients to mainstream housing and clinical supports. Caseworkers provide outreach, develop relationships and coordinate with other services to help people access needed services" (Employment and Social Development Canada, 2014). More intensive ACT teams focus on a "recovery-oriented, comprehensive, multi-professional model that usually includes comprehensive clinical supports, such as a psychiatrist, doctor, nurse and substance abuse specialists on a single team, and that team serves all of the client's

needs" (Employment and Social Development Canada, 2014). ICM and ACT teams can also work collaboratively to provide the most comprehensive supports for participants.

Homeless individuals entering housing and support programs, such as ACT or ICM, have been shown to have better quality of living when compared to those provided with standard treatment case management, or treatment first approaches. Individuals involved with ACT or ICM teams have been found to have fewer housing problems, a higher subjective quality of life regarding one's housing, and more choice and control over one's housing (Lipton, Nutt & Sabatini, 1988; Rosenheck et al., 2003; Tsemberis, Gulcur & Nakae, 2004). In terms of service use outcomes, existing studies show that ACT and ICM are more effective in decreasing hospitalization for psychiatric difficulties. In some studies, ACT and ICM emerged as clearly superior to other services by increasing outpatient service use, therefore leading to decreases in more expensive psychiatric and hospital emergency departments (Banks et al., 1999; Dharwadkar, 1994; Lehman et al., 1997; Lehman et al., 1999). Other studies showed a comparable level of effectiveness, but not as positive (Korr & Joseph, 1995; Wolff et al., 1997). The strong relationships that develop between service providers and tenants in ACT and ICM demonstrate that strong alliances improve retention in treatment, symptomology, quality of life and goal attainment (Howgego et al., 2003)

Three studies, have demonstrated that the combination of housing and support is superior to case management alone in reducing homelessness and hospitalization (Clark & Rich 2003; Hurlburt, Wood, & Hough, 1996; Rosenheck et al., 2003). There is also evidence in some studies that ACT and ICM were more effective compared to other services in improving consumer functioning and adaptation to living in the community

(Lehman et al., 1999; Morse et al., 1997; Shern et al., 2000). In the case of the Pathways to Housing model and the Mental Health Commission of Canada's At Home / Chez Soi project, ACT and ICM teams were used interchangeably depending on the participants perceived level of needs.

2.5.2 Pathways to Housing

The Pathways to Housing, Housing First model, is a consumer-driven approach that includes choice of housing, separation of housing and clinical treatment and delivery of recovery-oriented services that focus on facilitating community integration (Nelson, 2010). The Housing First approach is widely believed to have originated in 1999 with the Pathways to Housing program in New York City by Dr. Sam Tsemberis (Waegemaker, Schiff, & Rook, 2012). As mentioned earlier, due to "its progressive philosophy and its success in promoting positive outcomes demonstrated through rigorous research, the Pathways Housing First approach has been widely endorsed and disseminated as evidence-based practice" (Nelson et al. 2013, p. 17). The goal of the Pathways program is to end chronic homelessness by using a consumer-directed service approach which immediately provides consumers with what they want most: an apartment of their own, free of treatment and sobriety conditions (Tsemberis, 2010). The program is designed to meet the needs of homeless individuals living on the streets who have severe mental illnesses; 75% of participants have a dual-diagnosis, also known as concurrent disorder, which is described as a concurrent mental health diagnosis and addictive illnesses (Tsemberis & Eisenburg, 2000).

According to Greenwood, Stefancic, and Tsemberis (2013, p. 646), five aspects of this model marked a radical change in the standard homelessness intervention services (i.e. Treatment First approaches):

1. It revolutionized the order in which housing and services are delivered to homeless individuals with co-occurring diagnosis in the United States.
2. It relocated choice in housing and services from the service providing "experts" to consumers themselves.
3. It provided housing as a matter of right, not something to be earned by completing treatment or attaining sobriety.
4. It incorporated a harm reduction approach to psychiatric and substance abuse treatment.
5. From the beginning, research and evidence-based practice were integrated into each dimension of service delivery.

Consumer choice and self-determination are at the core of the "Pathways to Housing" framework. This framework believes that services are under the assumption that, consumers are the experts of their own lives and, as a consequence, are the best judge of what they need (Greenwood, Stefancic, & Tsemberis, 2013). With respect for individual personhood, dignity and autonomy, the Pathways Housing First program gives individuals the opportunity to make choices, take risks, and learn from their own mistakes. This allows individuals to understand the consequences of their choices through a process of trial and error in which there can be new learning gained from mistakes. It also allows individuals to take credit for their successes and to take responsibility for

their mistakes. Pathways also assumes that if individuals with psychiatric symptoms can survive on the streets they can manage their own apartments (Tsemberis, Gulcur, & Nakae, 2004, p. 653)

2.5.3 At Home / Chez Soi

An example of Housing First within the Canadian context, the "At Home/Chez Soi" Project, engaged and followed over 2,000 participants over a two year period and is an example of best-practice research of Housing First for not only Canada, but worldwide. The At Home/Chez Soi (AT/CS) research demonstration project was conducted by the Mental Health Commission of Canada (MHCC) and was funded by the federal government. In 2008 the federal government allocated $110 million to the MHCC to aid in housing and support to homeless people facing mental illness (MHCC, 2012). This funding is what culminated in the AT/CS project. The project looked at the efficacy of the Housing First approach for meeting the needs of homeless individuals with mental illness. Housing program participants were provided with an apartment, rent supplements and either Assertive Community Treatment (ACT) for those with high needs, or Intensive Case Management (ICM) for those with moderate needs (Goering et al. 2014). The project compared outcomes for Housing First participants with control groups who received conventional treatment and housing supports (ONPHA, 2013).

The At Home/Chez Soi project is the largest randomized control trial of the Housing First intervention, to date, worldwide (Goering et al., 2014). The ultimate goal of the project was to assess operational effectiveness and cost-effectiveness of the Housing First approach in the Canadian context, and to be better able to advise future policy and programs for homeless individuals in Canada (Hwang et al. 2012). In order to explore the

diversity of local context within Canada, the At Home/Chez Soi project incorporated findings from 5 separate Canadian cities with varying homeless population characteristics as well as housing and service contexts (Goering et al., 2014). The 5 cities included: Vancouver, with a focus on congregate housing and substance abuse issues; Winnipeg, looking more specifically at the urban aboriginal population; Toronto, targeting the needs of people from 'racialized' groups; Montreal, which added personalized employment supports; and Moncton, whose focus was on services in smaller communities (Gaetz, Scott, & Gulliver, 2013).

Across all sites Housing First participants obtained housing and retained their housing at a much higher rate than control group participants. Over the two years of the study, Housing First participants spent an average of 73 percent of their time stably housed, whereas the control group was only housed 32 percent of the time (Goering et al., 2014). In terms of cost effectiveness, the At Home/Chez Soi project found that the cost of Housing First for the top 10 percent of participants with the highest service use costs, cost on average $19,582 per person per year. This resulted in average reductions of $42,536 in service cost compared to usual care participants, or those in the control group. This means that every $10 invested in HF services resulted in an average savings of $21.72 (Goering et al., 2014). Another estimate for cost offsets and saving after one year due to decreased use of shelter, justice and health services by participants, who had previously been frequent users of such services, resulted in overall savings of $9,390 per person per year (Mental Health Commission of Canada, 2012).

While the At Home/Chez Soi project had successful outcomes for housing retention and cost savings, a universal barrier to program implementation across sites was lack of

affordable and available housing (Nelson et al., 2013).

2.6 Treatment First Versus Housing First: Some Existing Findings

The greatest difference between Housing First and Treatment First approaches is noticed at the initial phase. The Housing First approach reduces barriers to bringing homeless individuals indoors. It has been found to be more successful for both samples of homeless individuals recruited from the street, utilizing outreach programs, and samples recruited from psychiatric hospitals, for reducing literal homelessness and reducing hospitalization, respectively (Gulcur et al. 2003). In a report of Pathways to Housing with regards to housing retention, Pathways to Housing participants had higher percentages of time housed, 80-90 percent of the preceding six months in stable housing, in contrast to Treatment First control groups, whose time housed did not exceed 40 percent (Tsemberis, Gulcur, & Nakae, 2004). Similarly, another study found that in terms of substance abuse issues, Treatment First participants had higher rates of substance use and substance abuse treatment utilization (Padgett et al., 2011). This raises questions about the ability of Treatment First programs to engage clients and effectively treat their substance use issues if there is continual relapsing in high cost treatment services. Padgett et al. (2011) found that Housing First clients are significantly less likely to use or abuse substances when compared to Treatment First clients. Another study of Pathways to Housing found that housing individuals with concurrent serious mental illness and substance abuse without requiring abstinence and sobriety did not increase their use of substances during a 2-year period, despite lower levels of substance abuse treatment services (Padgett, Gulcur, & Tsemberis, 2006). While results regarding drug and alcohol use are not overwhelmingly

positive, the above studies have shown that requiring abstinence and sobriety does not achieve significant differences in substance use between Housing First and Treatment First approaches.

2.6.1 Systemic Change in a "workforce habituated to traditional services"

As mentioned previously, Housing First is now widely considered "best-practice" in providing housing and supports for the chronically and episodically homeless people. With regional and local governments seeking individualized strategies in order to implement this approach based on local contexts and funding structures, this represents a radical change in programs traditionally serving individuals experiencing homelessness and co-occurring psychiatric and substance use disorders (Tsemberis, 2010). In their study "Examining Provider Perspectives within Housing First and Traditional Programs", Henwood et al. (2013) compared the Pathways' Housing First and traditional programs in the U.S. in order to determine whether differences in perspectives of front line staff were found. The major focus of the study was to examine whether or not providers working with the Pathways Housing First (PHF) model versus the Treatment First (TF) model endorsed different views, values and perspectives in the context of their service delivery (Henwood et al., 2013, p. 264). This study found that PHF providers were far more likely to endorse consumer values; meaning staff supported an individual's right to independent housing and refusal of services under the assumption that who better to understand the proper supportive needs for participants than the participant themselves? On the other hand TF providers were more likely to endorse system values such as the need for individuals to be stabilized in treatment, to develop prior independent living skills or to be able to meet more stringent sobriety standards before being able to access independent

housing (Henwood et al., 2013). Due to programs increasingly adopting a Housing First approach, "implementation challenges remain due to an existing workforce habituated to traditional services" (Henwood et al., 2013, p. 263). While this study was conducted in the United States, Canada is in the process of making major changes with its housing and supports services, thanks to funding from HPS. The need to understand challenges that exist in the implementation of new Housing First programs, within the Canadian context, is now more important than ever for their future success.

2.6.2 The success of using a Housing First approach

In a randomized controlled trial conducted in 5 Canadian cities comparing Housing First participants utilizing ACT versus treatment as usual, found that, after a one-year follow-up, 73 percent of Housing First participants were still housed while the percentage that were still housed in treatment-as-usual was 31 percent (Aubry et al., 2015). Treatment-as-usual participants had access to outreach programs, drop-in-centres, shelters, and general health, addictions and social services. They also had access to many housing and support services not offered by the Housing First programs. In this study, after the one-year follow-up, they also found that Housing First participants had significantly greater improvements in overall health and showed greater improvements in community functioning compared to the treatment-as-usual control group (Aubry et al., 2015).

Results from a New York Pathways to Housing study found that individuals with severe mental illness and substance use problems did not have to undergo mandatory treatment to be able to live independently in the community (Padgett, Gulcur, &

Tsemberis, 2006). Providing increased choice over housing, one of the key principles of the Housing First approach can have a longstanding impact on residential stability and is relevant for reducing the stress of repeated moves and service costs associated with assisting consumers to relocate (Srebnik et al., 1995). Culhane, Metraux and Hadley (2002), demonstrated that individuals placed in subsidized housing with support used fewer shelter beds, were hospitalized less frequently and for shorter amounts of time, and spent less time incarcerated. Prior to placement, participants living with severe mental illness used about $40,449 per person per year in services. Housing placement was associated with a reduction in service use of $16,282 per unit of housing per year, while the annual cost of each unit was $17,277. As a result, there was an annual per housing unit cost of $995 U.S. dollars

In a qualitative study done by Yanos, Barrow, and Tsemberis (2004), they found that many participants indicated that becoming housed facilitated a feeling of being "normal" or part of the mainstream human experience. Individuals found that moving into housing improved their sense of safety, improved their self-esteem and helped them to feel a part of the community at large. Although some challenges still exist, such as individuals coping with loneliness or adjusting to the task of independent living (Yanos, Barrow, & Tsemberis, 2004, p. 139), providing an avenue for chronically homeless individuals to live independently with reduced homeless and emergency shelter services, reinforces the importance of focusing on intensive services and supports through ACT and ICM teams. Finally, existing research also shows that consumers who are dually diagnosed and homeless prefer independent living, but many clinicians still recommend supervised congregate housing for their clients (Schutt, Weinstein, & Penk, 2005).

2.7 Limitations to Housing First

While the Housing First philosophy is the latest approach to housing the most chronically homeless individuals, it still faces a range of challenges and criticisms. Proponents of the Treatment First approach argue that giving a chronically homeless individual a home before they are considered "housing ready" is essentially setting them up for failure (Pauly et al., 2011). Many of the findings associated with housing retention in Housing First programs refute that belief, showing that in fact providing a home from the onset does lead to greater housing stability. Although not all service providers agree with changing the structure of housing supports towards one that provides assistance with little preconditions.

There are also challenges associated with labelling and language in Housing First programs. A study in Calgary found that although many non-profits had begun to undertake activities resembling Housing First, fidelity to program models using best practice approaches, such as Pathways to Housing or Canada's AH/CS, varied across organizations. Some programs even continued to operate without significant changes to program structure, simply changing the language or labels used, designating them Housing First (Turner, 2014).

There are a variety of housing models that can be aligned with Housing First principles. The distinction needs to be made between "Housing First as a philosophy, emphasizing the right to housing, and as a specific program model of housing and wraparound supports, guided by consumer choice" (Turner, 2014, p. 7). Others believe that operating on a program-by-program structure limits the effectiveness of

homelessness-reduction goals issued by municipalities. Operating on a systems planning approach in which non-profits and government agencies co-ordinate diverse resources in order to work towards a common goal, to end homelessness, could be a much more effective way to alleviate repetition and duplication of services (Austen and Pauley, 2012; Burt, Pearson, & Montgomery, 2005; Greenberg & Rosenheck, 2010; Hambrick & Rog, 2000; Karper et al., 2008).

2.8 Summary

Approaches to homelessness support services are constantly changing and evolving to suit individuals in need. Political climates, as well as municipal, provincial and federal funding structures are constantly in flux. There will always be challenges associated with the adoption of a "universally" accepted philosophy or program structure. Cooperation and collaboration on a myriad of approaches may potentially lead to the most successful results but it may also create challenges in determining the most effective and balanced funding structure for each individual program. Thanks to studies like At Home/Chez Soi, Housing First is now widely considered the best approach to addressing chronic and episodic homelessness. With the increased adoption of Housing First as a philosophy and as a program model, understanding the perception of those who implement and operate these programs on a daily basis can provide professional and experienced insight into its successes and limitations within different local contexts and funding structures. As well, understanding the variation in local contexts faced by homeless individuals in different regions might provide a framework from which other municipalities could be successful in adopting new services as well as shape existing services in order to meet the specific

needs of their clientele. Resources such as the Canadian Housing Tool Kit (Polvere et al., 2014) and the Canadian Homeless Research Networks “Housing First in Canada: Supporting Communities to End Homelessness” (Gaetz, Scott, & Gulliver, 2013) provide communities with insight into planning and implementation of new Housing First programs. Giving a voice to those who work with existing Housing First programs might lead to further insight and preparedness. Interviews conducted with service providers and tenants within different regions in Southern Ontario might provide that insight needed for a more seamless adoption by other communities in Ontario.

CHAPTER 3

METHODS

3.1 Introduction

In order to understand the methodology used for this research, a reminder of the research objectives for this study are as follows:

1. Examine the perceptions of service providers on the major barriers to the successful implementation and operation of Housing First supportive services.
2. Investigate service provider and program participant perspectives on the benefits and limitations of Housing First approaches.
3. Assess the extent to which service providers agree that Housing First is the most effective approach to provide housing and supports for the chronically and episodically homeless.

To address these objectives, in-depth interviewing techniques and focus group discussion with service providers and tenants were used to gather the required data. This chapter is divided into 3 broad sections. First, an explanation of the researcher's philosophical standing and the process for the development of the research idea as well as the rationale for the use of qualitative research is discussed. Second, an overview of the methods used and techniques used for the coding and analysis of data is outlined. Finally, an explanation for the attainment of rigour and ethical considerations regarding the research is summarized.

3.2 Researchers Philosophy: genesis of the research idea

Bradshaw and Stratford (2005) stress the importance of documenting why researchers become interested in their research, why they chose to do it, and for what purpose, as a means of establishing rigour in research activity. Explicit theorising produces better quality research outcomes, and "provides a basis for a clear framework that enables the reader to scrutinize research on its own terms and avoid ambiguity" (Jacobs, Kemeny, & Manzi, 2004, p. 2). For this reason, a brief overview of how I became interested in the topic and the lens from which I analyze this study is discussed next.

My own interest and experience working with homeless individuals stems from volunteering and working at "Mission Services of London" where I gained firsthand experience working as both a data administrative assistant and "Crashbeds" worker, with individuals facing homelessness. Working in an office setting, and as front line staff, I heard a variety of opinions, mainly negative, expressed towards another program in London called "London CAReS", which is London's leading "Housing First" supported housing provider. Mission Services, which operates under a more "Treatment First" approach to supported housing, was dealing with a climate of social support funding instability and therefore funding for a variety of their programs was being cut. Negative opinion of the relative newcomer to housing support, London CAReS, and their Housing First philosophy seemed common at Mission Services as funding for homeless support services was being siphoned off from existing programs. This denouncing of one city's housing support program towards another, many individuals referring to it as "London Kills", led to the idea of documenting service provider perceptions of their own program. Due to the fact that the shift to Housing First support services is being favoured by all

levels of government, it can be assumed that many service providers, already working for a housing and homelessness support program, may not have willingly chosen to work for a program operating within the Housing First paradigm. While different programs work with many of the same clients and hopefully with the same goal, namely getting individuals off the street, I found it interesting that one program openly criticized and denounced the other. Understanding the differences and similarities in opinions from one agency to the next, in the case of this study within a Housing First framework, might be able to offer insight into common themes and potential consensus that may identify common ground with those operating within the Treatment First paradigm.

Through the use of qualitative research, researchers can collect a diversity of meaning, opinion and experiences, which can provide insight into differing opinions or debates within a group (Dunn, 2005). Qualitative research is interpretive in nature and when a researcher sifts through people's prior experiences and biases, looking at how they construct their understanding of the external world or how it is interpreted, it falls under the realm of constructionist research (Rubin and Rubin, 2012). According to Rubin and Rubin (2012, p. 16) "constructionist researchers accept that researchers, as well as research subjects, make interpretations and that it is neither possible nor desirable for researchers to eliminate all biases or expectations." The role of a constructionist philosophy in the study of housing is to develop theories in a field predominantly funded by government departments and agencies committed to a more positivist or empiricist understanding of evidence based-research (Jacobs & Manzi, 2000). Jacobs, Temeney and Manzi (2004, p. 3) argue "the strength of constructionism is its focus on broader social processes and its emphasis on the importance of social, political and economic context."

Constructionist philosophy gives merit to difference in individual perceptions. In this paradigm it is accepted that responses and opinions of the Housing First approach may vary substantially. For this reason, in-depth interviews were conducted with service providers from different programs in separate cities in order to offer a range of responses, in a variety of interpretive communities and settings.

3.3 Rationale for Qualitative Research

Qualitative research directly involves human experiences by using a variety of methods to promote the engagement of the study's participants, creating a rich source for the researcher's inquiry (Creswell, 2009; Kingsley et al., 2010). While still a relatively new topic of discussion within the Canadian context, with consideration to the At Home/Chez Soi report, there have been few qualitative studies focused on front-line staff working with "Housing First" approaches. The majority of studies up to this point focused primarily on participant or tenant perceptions of the model, and markers related to housing and health. Due to this lack of qualitative studies looking at service provider perceptions of the Housing First model, with the exception of a few studies conducted within the US analyzing PHF, and the At Home/Chez Soi report mentioned in Chapter 2, current studies, both quantitative and qualitative, may give the impressions that the Housing First model should be utilized over all other approaches due to its extremely high retention rates and cost savings. While housing retention rates are quantitatively significant in a study related to keeping chronically homeless individuals off the street, a more in depth qualitative analysis from the point of view of front line staff would be

beneficial in gaining a more thorough understanding of program operation and implementation challenges.

Qualitative research has been chosen as it provides information in a natural setting and seeks to understand meaning attributed to each individuals experience (Creswell, 2009; Yin, 2010). In many social science disciplines, quantitative orientations are often considered more valid perhaps due to the tendency of the general public to relate science to numbers and implying precision (Berg, 2009). While I will not argue against the merits of quantitative inquiry, the strength of qualitative methodology is its focus on capturing the authentic experiences and perspectives of those working with this model on a daily basis. Qualitative research has the capacity to capture the essence of human phenomena by revealing genuine experiences, feelings, beliefs and attitudes of participants (Hunt, 2011). One of the objectives of this study is to get a deeper understanding of the perceived benefits and limitations of Housing First as a model from the experiences of those who deal with it firsthand. Qualitative inquiry, and the approach of in-depth interviewing, permits a varied and detailed examination of the perceptions of service providers and tenants, which other quantitative methods, such as surveys, may not have the capacity to provide. The goal of this study is not to generalize findings but to develop and in-depth understanding of individualized techniques and perceptions of Housing First as a whole. As well, this study seeks to contribute to understanding the concerns and issues that service providers face in the implementation and operation of Housing First programs, and complement that data with tenant insight and first hand experiences working with one of the Housing First programs analyzed in this study. If there are

similarities in the concerns expressed by participants to those expressed by service providers, there is the potential that they will be revealed.

Finally, previously unanticipated themes that may have been missed in the design of quantitative studies may be revealed through the depth and richness of qualitative research data.

3.4 Methods

For the purpose of this research, interviews were conducted with service providers from Housing First agencies in two major Southern Ontario cities, London and Hamilton. A semi-structured, open-ended, interview technique was employed in order to allow service providers the opportunity to express ideas and concerns pertinent to the topic. Additionally, data was also gathered from a focus group discussion with service providers seeking to work more closely with Housing First services in the Waterloo Region. All data collection techniques, and explanations for the use of those techniques, will be described in further detail in the following chapters.

With regards to HF participants, data was gathered from a prior in-depth interview conducted with the participants of London CAReS. The interviews were part of a larger study conducted by the Lawson Health Research Institute, led by Principal Investigator Cheryl Forchuk, and co-investigators Richardson, J., Oudshoorn, A. & Csiernik, R., titled "An Assessment and Evaluation of London CAReS: Facilitating Service Integration Through Collaborative Best Practice". The evaluations funders were the "Homelessness Partnering Strategy" and the "City of London." All interview transcripts involving

participants were from this study and focused on perceived housing and health outcomes of participants of the London CAReS program.

3.4.1 Rationale for Interviews with Service Providers and Tenants

> "The qualitative interview probes human existence in detail. It gives access to subjective experiences and allows researchers to describe intimate aspects of people's life worlds" (Brinkman & Kvale, 2005, p. 157).

In-depth interviews were chosen as a method of data collection to provide the flexibility and opportunity to probe into the intricacies and subtleties of a participant's interpretation and understanding of a topic (Rubin & Rubin, 2012). In its most basic form in-depth interviewing can be understood as a conversation with a purpose, specifically, to gather information (Berg, 2009). With consideration to the work of Dunn (2005), this research relied on in-depth interviews as opposed to other research methods of data gathering for four main reasons. First, research interviews fill a gap in the knowledge where other methods, like observation or the use of quantitative statistics such as census data, may not effectively describe or portray specific information, such as firsthand account of events or individual perceptions. Second, interviews allow the researcher to understand complex behaviours and motivations of the participants being interviewed. Third, researchers can collect a diversity of meaning, opinion, and experiences, which may either provide insight into differing opinions or debates within a group, or the inverse, support some group consensus. Finally, interviews can empower those who provide the data and even give them cause to reflect on their experiences. In some cases this may give the interviewee the opportunity to reflect on potentially oppressive situations (Dunn 2005).

For this research, ten interviews in total were conducted with service providers in the cities of London and Hamilton (Table 3.1). Out of the ten, five were conducted with service providers from the City of London working with London CAReS and five service providers from the City of Hamilton working with Wesley Urban Ministries, Transitions to Homes program. Secondary analysis of open-ended interview transcripts from 65 participants involved with the London CAReS Housing First program was also conducted and will be discussed in greater detail in section 3.4.4.

Finally, five additional in-depth interviews were originally planned with service providers from "Supportive Housing of Waterloo" (SHOW) but that did not materialize due to time constraints on the part of the intended participants. Instead, a single focus group discussion was held with the service providers involved with the STEP Home Initiative as a substitute. The focus group is discussed in greater detail in section 3.4.5.

Table 3.1: Overview of Participants in the Study

City	**Program**	**Interviews**		**Focus Group**
		Service Providers	*Tenants*	
London	London CAReS	N=5	N=65	
Hamilton	Transitions to Home	N=5	N/A	
Waterloo	STEP Home	N/A	N/A	N=13

3.4.2 Identifying the Interview Participants

In this study, service providers were interviewed using a semi-structured interview format with open-ended questioning. Programs for inclusion in this study were chosen based on self-identification of the use of a "Housing First" paradigm within the programs mission statement or website, which were found through an online search. Due

to the limited number of programs that identified as using a Housing First approach within each city or region, programs in each city were primarily limited to one or two choices. Priority was given to programs with the most experience working with the model as well as any indication or consideration of either the Mental Health Commission of Canada's "At Home/Chez Soi" study or the founding "Pathways to Housing" program established by Dr. Sam Tsemberis mentioned in their program material. Identification and selection of each program was also largely based on those that were the largest operating Housing First programs in each respective city. In the selection of participants for this study, service providers were identified initially by contacting each program through email or over the phone. Due to the fact that the names of individual case managers, housing selection and housing support workers was not publicly available, contact information of program managers, or executive directors was obtained, whereupon permission was granted by them to contact individual case managers, housing workers and case manager supervisors. Consent to participate in the study as a volunteer was requested after meetings were conducted to provide an opportunity for potential subjects to ask questions and for them to establish a trusting relationship and rapport with the researcher (Creswell, 2007). Each participant was informed of all aspects of the research study such as: time commitment, purpose of the study and its objectives, data collection methods as well as the role as a researcher (Creswell, 2009). Copies of Western's Research Ethics Committee consent form and an overview of the research objectives was sent to all participants. Convenience sampling was used due to a finite number of participants available for questioning (Glicken, 2003) and logistical restraints around not having access to all case managers for interviewing.

3.4.3 Conducting the Interviews with Service Providers

The data was gathered during individual face-to-face interviews using semi-structured questions as a guide. This format, according to Creswell (2009) is flexible and has the ability to change during the research process. This form of interviewing also gives the researcher the ability to change the wording and order of questions, as well as implement probing questions in order to clarify or elaborate on responses. Semi-structured interviews allow for freedom and flexibility but still require a set list of predetermined questions or topics before initially conducting the interview (Berg, 2009). The use of active listening, observation and field note-taking was employed in order to engage the participants to help them feel comfortable and make them feel that their opinions and feedback mattered and were significant to the study. The goal was to provide a flexible environment in which the interviewee has the power to direct the questioning or perhaps adjust the emphasis of the specific topic or question during the interview. This allows for issues to emerge from the interview that the interviewee found to be the most important, and therefore, later made apparent in the results (Bryman, Teevan & Bell, 2009).

As part of making the participants feel as comfortable as possible, they were given the flexibility to choose the location of the interview. This flexibility of location was adopted due to the importance of location in helping participants provide meaningful insights to the research (Elwood & Martin, 2000) and mitigate any issues pertaining to power structures associated with the location of the interview (Elwood and Martin, 2000; Kvale, 2006). All interviews took place between June and September 2014 and lasted

between 40 and 70 minutes. Interviews were audio recorded with consent from the participants.

Questions were included involving service providers understanding of Housing First (i.e. What are the major differences between the Housing First approach and other approaches you have dealt with?), service providers approaches to dealing with clients (i.e. Do you have your own approach or technique to dealing with clients or do you follow approaches outlined by your organization?), and challenges in the implementation of a Housing First approach (i.e. What were some of the main challenges for your organization in implementing a Housing First Program). A full list of questions can be found in Appendix A.

3.4.4 Conducting Interviews with Tenants

The original plan for participant interviews was to interview 15 individuals involved in the London CAReS program and to assess the perceptions and understanding of Housing First as a whole, as well as to understand the opinions of tenants regarding the accomplishments and limitations of London CAReS services. However upon arranging interviews for the research it came to light that another study entitled "An Assessment and Evaluation of London CAReS: Facilitating Service Integration through Collaborative Best Practices" had recently been conducted on London CAReS participants and involvement with another research project was seen as undesirable to London CAReS staff due to logistical restraints and interview fatigue of their clients. Thankfully, with the assistance of Dr. Cheryl Forchuk and the Lawson Health Research Institute (LHRI), access was granted to baseline and follow-up interview and focus group transcripts encompassing data collected from approximately 65 participants. Secondary analysis of

that data was decided as the best course of action so as not to repeat interviews with the same participants of the London CAReS program.

Three open-ended interviews were conducted with 65 participants over a period of one year. Interviews were completed: first, at the onset of participation in the study; second, 6 months after the initial interviews and third, at the end of the study, 12 months after the initial interview. So as not to change the order of questioning, wording or deviations from the topic at hand, a structured interview style was used. Structured interviews use an interview schedule that "typically comprises a list of carefully worded and ordered questions. Each respondent or informant was asked the exact same questions in exactly the same order" (Dunn, 2005, p. 83). Seven questions were asked concerning topics such as the overall health and housing outcomes of participation in the London CAReS program, as well as the overall opinion of the experiences participants had with their involvement in the program. Responses to all seven questions were transcribed and categorized into responses associated with each individual question at hand. The full list of questions can be found in Appendix B.

3.4.5 Focus Group – Waterloo Region's STEP Home initiative

As mentioned in section 3.4.1, in-depth interviews with service providers from SHOW were originally planned. Unfortunately, also due to logistical restraints and time constraints on the part of service providers, participation in a focus group was recommended as an alternative. The invitation to participle in the focus group was offered by the Manager of Social Planning for the Region Waterloo and was run by researchers in association with the At Home/Chez Soi project. The goal of the focus group was to provide a follow up to the AH/CS project in order to share information

about supportive housing and HF approaches in Canada based on information gathered from AH/CS. It was also intended to help communities that were interested in adopting HF approaches to have the necessary information and supports in order to have a more effective HF program reflecting best practice approaches. One of the purposes of the focus group was to act as a needs assessment in order to assess what assistance was needed in the region of Waterloo for further training. Although in-depth interviews of service providers from one specific program were not possible, this meeting was productive as it provided simultaneous access to all major housing support and homelessness agencies from the Waterloo region (i.e. the Cities of Kitchener, Cambridge and Waterloo). Those in attendance were 11 key informants, 2 lead researchers from Wilfrid Laurier University and this researcher. The 11 key informants from different governmental and non-profit agencies in the region provided insight into potential needs and limitations of HF programming as well as service provider perceptions of the current state of supportive housing based on their respective communities. A full list of agencies present can be found in Appendix C.

Two researchers led the focus group from Wilfrid Laurier University in Association with the AH/CS project, as part of a needs assessment and a national knowledge translation network to share strategies and information to other HF programs. The focus group lasted approximately one hour and involved topics such as inter-agency collaboration, limitations in the scope of programming and potential funding structures for new programs. These topics were intended to be explored with program specific in-depth interviews, but due to restrictions on the part of SHOW, participation in the STEP Home Initiative Focus group was provided as an alternative. It is worthwhile to note that

although the focus group was not originally planned as part of the data collection approach, the use of more than one qualitative method allows for richer insights as well as triangulation of data, minimizes the possibility of misinterpretation of narratives (Baxter & Eyles, 1997) and allows for a more comprehensive understanding regarding participant experiences (Gatrell & Elliott, 2009).

3.5 Outline of HF Programs Involved in the Research

In order to better understand challenges faced by HF programs in Southern Ontario, qualitative research methods analyzing the internal and external issues of three programs, in different stages of development and service proficiency was determined as the best course of action for the research. The three programs involved with the study had varying levels of expertise, year of establishment, and program structure. As was discussed in Chapter 2, studies have shown a range of variability in their core principles regarding HF (McHugo et al., 2004; Rog & Randolph, 2002; Wong, Filoromo, & Tennille, 2007; Turner, 2014) and while a program may label themselves "Housing First", meeting the proper fidelity standards outlined by MHCC's Housing First Toolkit (Polvere et al, 2014) reflecting proper program structure and the best overall outcomes, utilized by evidence based studies such as AH/CS, may be problematic. A brief outline of the two programs whose service providers participated in in-depth interviews (LC and T2H) is summarized below to highlight differences between programs in their approach and structure. Due to STEP Home involving a variety of different programs in the Waterloo Region, outlines of each program involved will not be discussed below.

3.5.1 Transitions to Home (T2H)

The most experienced of the three programs involved in this study, Transitions to Home (T2H) was an evolution from the pilot project "Hostels to Homes" which was in place from 2007-2009 in Hamilton (Gaetz, Scott, & Gulliver, 2013). After findings of the project found that 80% of individuals were still successfully housed at the one-year follow-up, stakeholders were on board. The implementation of Transitions to Home (T2H) led by Wesley Urban Ministries was due to collaboration with agencies within the homelessness sector, including all emergency shelters in Hamilton. The program targets long-term shelters users and follows major pillars of the HF approach. ACT teams are not part of the T2H program but ICM with caseloads averaging 18-20 individuals is the norm (Gaetz, Scott, & Gulliver, 2013). Service providers also have clients in "maintenance" meaning participants are not receiving active case management from T2H but can reconnect whenever they feel necessary. A T2H team is composed of case managers, a housing worker, a supervisor, a manager, a therapeutic recreation therapist, an addictions worker and a part time nurse (although the addictions worker and nurse were no longer part of the program upon initial interviewing). According to Gaetz, Scott, and Gulliver (2013) 55% of clients receive Ontario Works (OW) and 45% receive aid from the Ontario Disability Support Program (ODSP) so the majority of clients do not receive a rental supplement from T2H.

3.5.2 London CAReS (LC)

London CAReS was established in 2008 after the growing homeless population in London was recognized by community agencies and a change in approach was needed to

address those needs. LC is a collaboration between The Regional HIV/AIDS, Addiction Services Thames Valley, and the Unity Project Relief of Homelessness (Meyer, 2014). Starting in 2008 the City of London, the exclusive funder of London CAReS, set a course of action to address the changing needs of homeless service in the community by contributing $1.25 million annually for 5 years. London CAReS involved street outreach, 24hr crisis support and a needle exchange program. After the first three years of its implementation, London CAReS faced issues surrounding its lack of supports for individuals transitioning off the street or out of shelters back into the community, no focus on housing and no philosophical alignment in its programming (Martin, 2014). In 2011, the implementation of London CAReS 2.0 took place in order to address the lack of supports found with its predecessor. The new focus of LC 2.0 concentrated on effectively transitioning individuals off the street and into housing with consumer driven supports. This transition utilized Housing First as its guiding philosophy and its approach to housing the chronically and episodically homeless in London. LC teams consist of 'housing-focused' outreach workers, case managers, supervisors, and a program manager. LC uses mobile ICM, with participant to service provider ratios of 10:1 in order to most effectively address client concerns and crises.

3.5.3 STEP Home Initiative

After the release of "All Roads Lead to Home: A Homelessness to Housing Stability Strategy for Waterloo Region" by community stakeholders in 2007, funding for programs in Kitchener, Cambridge and Waterloo, designed specifically to support people experiencing persistent homelessness began. This funding started in 2008 and was extended until 2011. Starting with 4 programs in 2008, by 2011 the STEP Home

Initiative consisted of 12 programs, delivered through ten different agencies, at 19 sites. They are all still in operation today. The STEP Home initiative involves "programs and groups that work together as elements of a single coordinated strategy to address barriers to housing stability at both the individual and system level with an ultimate goal to provide options and support to end persistent homelessness in Waterloo Region" (Social Planning, Policy and Program Administration, 2012, p. 1). Table 3.2 provides an outline of the 12 different programs involved in STEP Home.

Table 3.2 List of STEP Home Programs

Program and Funding Source[6]	Site	Start Date
GENERAL STREET OUTREACH (2 programs)		
Street Outreach (HPS; WW-LHIN[7], CHPP[8], HHSS)	The Working Centre	2002 (joined STEP Home in 2008)
	Cambridge Self-Help Food Bank (in partnership with The Working Centre)	January 2010
	ROOF	2003 (joined STEP Home in September 2011)
Peer Health Worker Program (HHSS)	Kitchener Downtown Community Health Centre	2008 (joined STEP Home in June 2011)
SPECIALIZED STREET OUTREACH (2 programs)		
Psychiatric Outreach Project	The Working Centre	2005 (joined STEP Home in 2011)
At Home Outreach (WW-LHIN)	The Working Centre	November 2008
INTENSIVE SUPPORT PROGRAMS* (4 programs)		
Streets to Housing Stability (HPS[9]; HHSS[10])*	The Working Centre	May 2008
	YWCA-Mary's Place	June 2008
	Cambridge Shelter	January 2010
Shelters to Housing Stability (HHSS)*	YWCA-Mary's Place	June 2008
	Cambridge Shelter	July 2008
	Charles St. Men's Hostel	October 2008
	Argus Residence for Young People	January 2010
Circle of Friends (HHSS)	YWCA-Mary's Place	2002 (joined STEP Home in June 2011)
Peer Program (Trillium)	Cambridge Shelter	June 2011
SUPPORTIVE HOUSING (3 programs)		
Hospitality House (HPS; WW-LHIN)	The Working Centre	April 2009
SHOW (DH[11], HHSS)	362 Erb St. W.	June 2010
Five Beds to Home	Argus Residence for Young Men	July 2010
SYSTEM-LEVEL (1 program)		
Whatever It Takes (WIT) – Service Resolution (HPS)	Lutherwood	October 2008

* *Intensive support programs are included within the Housing Stability System under the Housing Retention and Re-housing program area.*

6 Note that programs may have additional funding from community sources
7 Refers to provincial funding through the Ministry of Health and Long-term Care – Waterloo-Wellington Local Health Integration Network
8 Refers to provincial funding through the Consolidated Homelessness Prevention Program
9 Refers to the federal Homelessness Partnering Strategy
10 Refers to the Region's Homelessness to Housing Stability Strategy funding
11 Refers to the provincial Domiciliary Hostel Program

(Social Planning, Policy and Program Administration, 2012, p. 1)

3.6 Coding and Analysis of Data

In preparation for coding and analysis, data from in-depth interviews, focus groups and field notes were transcribed, coded and organized into categories. The purpose of coding is threefold; it is done as a means of data reduction (to help the researcher find themes in the data), organization (to help the researcher navigate the data), as well as exploration, analysis and theory building (Cope, 2005). Essentially, coding is used as a way of allowing the researcher to organize texts and identify patterns (Auerbach and Silverstein, 2003). After transcription of interviews, key themes and phrases within the text were identified and categorized in order to be more easily accessible. Based on interview and focus group transcripts of service providers and program participants a list of 16 themes was made. Afterwards, further grouping into 10 major themes followed by manual coding of all transcripts based on those ten themes. This was completed in order to properly analyze and interpret responses from multiple transcripts that align with a particular research question. Cope (2005, p. 226) sees coding as a form of analysis which starts as a "recursive juggling act of initial codes that come from the research questions, background literature, and categories inherent in the project" and evolves in to a reflexive reanalysis "as new themes emerge, previously coded material will need to be re-coded to include the new concepts." Berg (2009) likens code development as similar to solving a puzzle, as more pieces come together in the coding process, a more complete picture can be achieved. In the analysis of content from both focus groups and interviews, continuous interpretation of key themes and categories was necessary so that the subjective opinions of the participants aligned properly with the research objectives of the study.

3.7 Achieving Rigour

The key to achieving rigour in qualitative research is essentially to establish "trustworthiness" in our work (Bailey, White, & Pain, 1999; Baxter & Eyles 1999). Trust is assessed by our participants and interpretive community and "is not assumed but needs to be earned" (Bradshaw & Stratford, 2005). Strategies used to ensure trustworthiness need to be utilized in the early stages of research as well as throughout the research process (Baxter & Eyles, 1999, Lincoln & Guba, 1985). Triangulation of the research, outlined by Baxter and Eyles (1997), through multiple sources, methods, investigators, and theories can be used as procedures by which our interpretive and participant communities can assess our work. Member checking and researcher reflexivity are two important validity procedures outlined by Creswell and Miller (2000) in the interview process. While member checking was not achieved in this study, making sure the information discussed was representative of ideas and themes expressed by interview and focus group participants was of utmost importance to this researcher. Accurately portraying the views of all participants was based on the assumption that under the circumstance that individuals involved in this study were to read this thesis, recognition of major themes would be apparent. In member checking the lens of the researcher is focused on the research participants, researcher reflexivity takes the view of the researcher, positioned within a critical paradigm where individuals self-reflect on the social, cultural, and historical forces that shape their interpretations. Researcher reflexivity was incorporated throughout and determined to be an integral part of the study

and involves a researcher self-disclosing assumptions, beliefs, and biases that may shape their inquiry (Creswell, 2009; Miller & Crabtree, 2009).

3.7.1 Methodological Rigour: Credibility, Dependability, Transferability and Confirmability

Lincoln and Guba (1985) argue that ensuring credibility is one of the most important factors in establishing trustworthiness. To ensure credibility, interview transcripts were interpreted and presented in a way that "those having the experience would recognize it immediately and those outside the experience can understand it" (Baxter & Eyles, 1997, p. 512). Although member checking was not conducted within this study, attempts were made by this researcher to ensure interviewee quotes were presented in a way that, if made available, the interviewees could recognize their experience upon seeing the write-up. Triangulation through the use of in-depth interviews, focus groups and secondary data as well as the involvement of front line staff, key informants and tenants provided the outlet to document diverse experiences and opinions of those most familiar working with Housing First programs. These different forms of triangulation provided the necessary insight needed for achieving credibility.

According to Lincoln and Guba (1985), demonstration of credible research leads to ensuring a dependable study. This can be achieved through the use of "overlapping methods" such as focus groups and individual interviews (Shenton, 2004). Bradshaw and Stratford (2005) argue that it is vital to document all stages of the research process so that checking on the part of our interpretive and participant communities can lead to our work being considered dependable. Demonstration of the examination of literature dealing with the general area of the research and the research methods the researcher intends to use, as

well as, confirmation of the plausibility of the study from supervisors and colleagues also supports the dependability of the research (Bradshaw & Stratford, 2005). Research is considered dependable if there is the potential for future researchers to repeat the same research processes and potentially gain the same or similar results (Shenton, 2004).

This study was conducted in three separate cities in Southern Ontario with the goal of documenting program variability and perceived benefits and limitations of the program in question. While dependability refers to the extent in which using the same methods in future research could lead to similar findings, transferability is concerned with the external validity of a study, in other words, its ability to be applied to other situations outside of this particular research context (Merriam, 1998). The data collected for this research was collected from three separate communities in Southern Ontario with the aim of contributing insights into shaping future programs in the area as well as potentially providing for change in existing ones. Although this study contributes to the knowledge base in this region it may not be readily transferable to other programs outside Ontario or indeed Canada. However, with appropriate consideration to context, some amount of transferability may be possible, given the commonality of themes and experiences expressed by those facing chronic homelessness. "It is also important that sufficient thick description of the phenomenon under investigation is provided to allow readers to have a proper understanding of it, thereby enabling them to compare the instances of the phenomenon described in the research report with those that they have seen emerge in their situations" (Shenton, 2004, p. 70).

Confirmability relates to ensuring researchers objectivity with the research topic. In other words, ensuring that the findings accurately reflect responses and opinions

provided by the informants and not inherently subjective interpretation of the researcher (Shenton, 2004). Triangulation and direct quotes from interviewee transcripts can minimize the researcher bias and interpretation of the data. A key criterion for confirmability is the extent to which a researcher identifies his or her predispositions (Miles & Humberman, 1994). By documenting how we came to be interested in the research, why we chose to do it, and for what purpose as well as declaring philosophical and theoretical inclinations we can inform the reader as to why we chose to embark on the research (Bradshaw & Stratford, 2005). These were documented earlier within this chapter.

3.8 Ethical Considerations

Due to the sensitivity of the topic in question, especially in regard to responses obtained from chronically homeless individuals living with concurrent disorders, mental illness and addictions which are both highly prevalent within the homeless population especially those experiencing chronic homelessness, the highest ethical standards must prevail. Therefore, steps were taken in order to ensure anonymity of participants as well as careful examination of questioning in order to limit responses pertaining to potentially sensitive issues on the part of the participants (Bradshaw & Stratford, 2005). For this reason, in the process of identifying interview participants for the tenant portion of this study, secondary analysis of interview and focus group transcripts from a London CAReS assessment and evaluation study was recommended. Recommendations, from both the lead investigator from the Lawson Health Research Institute, as well as the managing director of London CAReS to utilize data obtained from their research allowed for

limited disturbance of the lives of London CAReS participants and the need for re-questioning on sensitive topics and a duplication of similar responses.

For interviews involving service providers, the risks and benefits of the research were explained to the interviewees at the onset of the interview and steps were taken to ensure that the participants understood the importance of anonymity in the study and that at any time they could refuse to participate or withdraw from the study, even after signing a consent form.

Steps were taken to ensure anonymity such as the use of pseudonyms, the removal of any identifiers, and ensuring that the data was password locked and accessible to only me, and my thesis supervisor. Interviews involving tenants, or HF participants, were removed of all markers and sensitive issues before the data was provided to this researcher. Due to the trust and rapport built with many of the participants in this study, consideration of power gradients in relations between the interviewer and interviewee needed to be taken into consideration and how this may lead to potentially unguarded responses (Burman, 1997). While some of these unguarded responses may be harmful to the participants and others may not, the importance of rapport building between interviewer and interviewee was an aspect of the interview process, referred by many, as an essential part of facilitating an effective interview (Berg, 2009; Bryman, Teevan & Bell, 2009; Dunn, 2005; Miller & Crabtree, 2004; Kvale, 2006). Rapport building with research participants creates trust and serves as a means to efficiently obtain a disclosure of the subjects' world. Unfortunately, rapport building and trusting supportive relationships can lead to a "Trojan Horse" (Fog, 2004), in which the researcher gets behind the walls of the interview subjects, where they disclose private information to a

stranger, which they may later regret. While these unintended consequences of the interview process are not inevitable, it is still important to stress their manipulative potentials if power considerations are not taken into account.

As required by Western for any research involving human participants, approval for this research was obtained from the Office of Research Ethics at Western University in April of 2014 (see appendix D).

3.9 Limitations of the Study

One limitation of this study was the use of convenience sampling as a means of recruiting participants. Due to the limited number of programs in each city utilizing a Housing First approach, sampling was only done on the most longstanding programs in each city which self-identified as using a Housing First approach within their program. The total population from which to sample was limited, as each program only employed between 10-15 front line staff.

In regards to service providers, another limitation was that responses of those operating under a different supportive housing paradigm (i.e. the traditional approach or treatment first approach) were not collected due to the study's focus on Housing First service providers. Also, the potential for guarded responses from individuals operating within the Housing First realm, who may be afraid to lose their jobs, may have led to interviewees being reluctant to disclose all information.

3.10 Chapter Summary

As previously mentioned, Bradshaw and Stratford (2005) stress the importance of documenting how researchers came to be interested in the research, why we chose to do it, and for what purpose. Bradshaw and Stratford (2005) also mentioned the importance of declaring philosophical, theoretical, and political inclinations in order to inform the reader as to why we chose to embark on a particular research. This chapter, as well as Chapters 1 and 2, have outlined this researcher's inclinations and intended purpose for the study. Using in-depth interviews to capture service provider and tenant perceptions of the Housing First model in three separate programs from varying geographic locations and social support structures, develops a better understanding of social support services needs for effectively advocating on behalf of chronically homeless populations in Southern Ontario. Chapters 4 and 5 will explore varying accounts of Housing First support services in various localities in order to provide recommendations and potentially educate future programs on the merits or disadvantages of adopting a Housing First program in there municipality.

CHAPTER 4: RESULTS

SERVICE PROVIDERS' PERSPECTIVES ON HOUSING FIRST PROGRAMS

4.1 Introduction

A major objective of this study was to understand, from the perspectives of front line staff of Housing First programs, the merits and limitations of Housing First (HF) as a philosophy as well as an approach to supportive housing. HF is now considered the "best practice" approach to housing and supports for the most intense users of homeless services. Understanding the challenges faced by those who use this approach on a daily basis can offer insights into some of the disconnects between policymakers and front-line staff.

As noted in Chapter 3, in-depth interviews were carried out with service providers from the City of London's London CAReS program and Hamilton's Transitions 2 Homes program and a focus group discussion involving community partners in Waterloo's STEP Home project. Themes and constructs related to the key research objectives guided the analysis. All interview responses were categorized by themes, putting similar themes in the same category. Due to the nature of conducting a semi-structured interview, interviewees were given the opportunity to discuss topics that were of most importance to them and the line of questioning followed those responses. In some cases, service providers discussed certain topics more extensively than others. In order to best represent some of the challenges service providers face in the everyday operation and successful

implementation of HF, this chapter will first outline the more specific challenges service providers face, followed by more general criticisms and opinions regarding the successes of the HF approach.

This chapter is arranged into five broad sections. Section 1 deals with service provider perceptions of changes to program structure from the traditional, “Treatment First” approach to the newer Housing First Approach. Section 2 deals with some external or system challenges associated with housing retention and the success of program implementation and operation. In section 3 an overview of some of the challenges associated with service provider-participant relationships regarding housing retention and program implementation and operation will be discussed. Section 4 focuses on the interpersonal challenges faced by service providers within their community, between agencies or with housing providers. Finally, section 5 provides more sweeping generalizations and overall opinions of Housing First as not only a philosophy but also as an approach to supportive housing.

4.2 The Changing Paradigm towards Housing First

As mentioned in Chapter 2, a Housing First approach to housing the homeless is relatively recent, dating to about 1999 (Tsemberis & Eisenburg, 2000). Prior to this program, services followed the more dominant homeless supports such as Treatment First or the Continuum of Care models. In Canada, changes to the Housing First approach are much more recent and some of the agencies and interviewee’s that were part of this study, have previous working experience with the more traditional models. In this

section, understanding service provider's perceived need for change, as well as the opinions regarding that change, is outlined.

Of the three organizations that took part in this study, each had gone through some form of transition to "Housing First" approaches at different points in their agencies' development. Waterloo's STEP Home initiative experienced the most recent changes in their program development. The STEP Home initiative is currently in the process of following a more "Pathways to Housing" approach to Housing First across the region of Waterloo. The more seasoned service providers, or the ones with experiences operating within the Housing First framework were those that were involved with Wesley Urban Ministries, Transitions to Homes (T2H) project and the London CAReS project. Not surprisingly, the majority of comments regarding the transition from 'the old way' to 'the new way' to housing the homeless came from service providers who experienced the most recent program evolution: London CAReS and STEP Home.

For the most part, service providers from all agencies agreed that the 'old way' of simply providing Treatment First approaches and trying to work with a transient homeless population through shifting shelter accommodation needed change. A major reason cited relates to the ineffectiveness of the previous approach. To illustrate this perspective, one participant commented as follows:

> "I think that all of the agencies came to a point where they recognized that what happened before wasn't necessarily working and that there was a collective understanding that the agencies needed to put their heads together and try to reconsider its approach and support." (STEP)

Other service providers echoed similar views, stating that the need for a change in approach was a collective one—that is, from their perspective as well as those of various partner agencies and clients. In fact, when asked about previous experiences, some service providers described clients' experiences with previous approaches as "frustration", "dissatisfied" or "failure", and expressed concerns about the relative lack of success. For instance, two participants, commenting on the lack of success with the previous approaches, indicated that:

> "We were hearing from people with lived experience, or participants in the programs, that they were generally pretty frustrated and feeling as though they had gotten to a point where they hadn't experienced a lot of success at housing. A lot of service providers were also at a point where they really didn't know what to do, and I think that there is a point where people were prepared to come together, on the part of the individuals and the service provider as well, to try to put their heads together and figure a way through it…. They decided to change the way they were doing things, as opposed to trying to change the person to fit into housing." (STEP)

> "Everyone recognized that housing is an absolute right and we can't do our work if nobody is stably housed or if the folks were trying to help aren't stably housed. We were all feeling some frustrations around trying to fit those that we were working with into a model that didn't suit them. Our gut feeling was that the old way is not the way to do it, that there's got to be a better way." (STEP)

Interview participants associated with the Waterloo Regions STEP Home initiative focus group, who faced the most recent changes in program structure, frequently commented on the need for change. Similarly service providers from the London CAReS program, a more experienced organization in the Housing First approach, commented on some aspect of the shelter system and the challenges associated with the operation of the previous model. One participant said:

> "Shelters were seen as the end-all, be-all, of anything related to homeless supports. You would go there get your meal; get your bed, maybe you get some case management, maybe you get some rec and leisure. Some people can filter through that relatively easily and find housing quickly, but others really struggle

> with it and become sort of main stays of that institution for years and years and years. It seems like some agencies are either reluctant to engage with how to do things to meet the needs of that person' or just accepted that they're there. It's almost like a bar that has a regular, you just kind of assume that they're always going to be there and they're just part of the tapestry." (LC1)

Stating the importance of shelters for many transitionally and episodically homeless individuals, the same service provider stressed the challenges associated with those experiencing chronic homelessness:

> "[Looking at] people that have been [in shelter], chronically, who have been staying [in shelter] inappropriately, I mean it really causes you to have to define a shelter as being that. It's an EMERGENCY shelter, right? It's not just a place you can go and hang out and sleep if you need to. It's meant for specific purposes and in that sense it's being used inappropriately by a large amount of people." (LC1)

One service provider who previously worked as a case manager within a shelter in London expressed a similar challenge, by stating:

> "One of the things that I struggled with was that I would have a caseload everyday between 20 and 30 people and it would change every single day because somebody would be kicked out of shelter, new people would come in, or people would only be staying for a couple days and it was really difficult to do any long term planning or case management with people. It was a lot of crisis management and deciding what to do in the next 30 days while they're in shelter." (LC3)

The same service provider, along with others, expressed the importance of shelters for those familiarized with institutionalized living (i.e. previous experience in foster care, juvenile detention or jails). For many of the long-term users, it was something they got used to and were unwilling to change.

> "With people who are institutionalized throughout their life, they find certain comfort within the shelter system, and it's not our job to try to convince them to get their own place, it's just our job to offer them an opportunity and see an apartment or, for lack of a better term, a foot in the door. Once people start to check out places they start to envision themselves in that space, it starts to break down whatever hang-up they had about living on their own and not being around people." (LC5)

Once someone is housed with the assistance of a shelter worker, the lack of supports once housing is found makes recidivism back into the shelter system quite common, especially among the chronically homeless. Without the extensive supports provided by programs using an HF approach, keeping people housed who are used to the institutionalized routine of shelter living can be challenging. The whole purpose of HF is to give individuals a chance to get out of the cycle of repeated shelter stays.

Interviewees offered opinions about what they thought individuals working within the homeless sector and more traditional approaches for extended periods of time might believe HF programs represent. In the comments below, two service providers shared their thoughts as follows:

> "People didn't like the term Housing First. There was a lot of misconception about it being 'Housing Force'." (STEP).
>
> "People had grown fearful of what Housing First might do to the sector creating that paradigm shift. They just assume that all of a sudden shelters were going to become obsolete and within a year there would be no need for them." (LC3)

These were some of the justifications that were used by HF service providers in understanding the hostility they found in trying to collaborate with other agencies within the community.

When asked about any push back from emergency shelters or other community agencies some of the service providers had this to say:

> "Emergency shelters are a haven. They're a place where you can go when you have nowhere else to go; it's really about just saying, 'this is a place that you can come to.' I think people forget that, yes, this is the place that you can come to but it's really just a short-term stabilization space to get you back out and anchored in your community. I think that's a piece that a lot of folks that work within this sector for a long time forget or perhaps become sceptical of… 'Oh they've been

> housed a bunch of times before and they keep coming back' or 'yeah, they're housed, but then they're out there with no supports. They'll be back'. So it's hard for people to see that change can be possible when you've seen this kind of recurrence for such a long time. I don't know if people necessarily push back, I think that people are just a bit sceptical. And I think there's probably a genuine concern if people are saying, 'If I was not here to look after them in this 'controlled environment of an emergency shelter' or where ever, what's going to happen when they're out there? Are they potentially going to be a greater harm to themselves out in the community than they would in this controlled environment?'." (LC2)

> "Service providers seem to have this attachment to certain individuals. They might not want to see them housed or have a problem with them being connected with another agency. We should ultimately have the same goal. We should want to see success within them. There's just this sense of autonomy that seems to take over people when they want to be the ones to see a success change within [clients]. It's taken a really long time to build relationships [with other agencies] and it was really hard initially to understand why. Why do these agencies dislike us? Is it because we are seeing continued success? Is it because we are making change in something familiar? I truly believe that's sort of where [the disagreements] came from." (LC4)

> "I remember there being some pushback from some agencies, 'serving 1 to 10 that ridiculous! 'There's so much need out there and so many people we want to serve, those folks that are seeing persistent homelessness need a different level of support, a different approach, we need to be persistent in our approach with them." (STEP)

The call for persistent and continued supports by service providers 24/7, is a major pillar of HF programs. Something that was not always provided by some of the older approaches to supportive housing, as one interviewee mentioned:

> "People in need who experience homelessness might not need supports during more common working hours. Some people find themselves in vulnerable situations 24 hours a day 7 days a week." (LC2)

Having supports available when someone is in crisis is important to a client's housing retention and is a major part of the success of Housing First programs.

Homeless support services are constantly changing and changes never come without some form of negativity and pushback from a segment of the population. Changes take time and typically involve extensive collaboration with a variety of community partners and stakeholders. As one interviewee expressed in this metaphor:

> "What we were talking about is a significant paradigm shift right so any large organization whether its emergency shelters or hospitals or police; it's kind of like trying to steer a ship right and it takes a lot to change its direction to change its course." (LC2)

Various focus group members expressed a similar idea. The goals and approaches to participant supports vary amongst organizations and service providers. While one universal program may be ideal in the eyes of some, it is not a realistic undertaking according to others. Locally specific initiatives need to be in place to address matters which are distinct to each city or municipality. As is seen in a comment regarding changes being made towards HF:

> "I think rather than shift, it's almost like we are evolving. We're listening to our participants, we're listening to landlords, the funders are listening to us, we're listening to each other and we're evolving along with the needs of those that we are trying to support. We're really taking something and trying to make it true to our community, instead of utilizing a cookie cutter program, trying to fit our community into it, we're allowing it to evolve and create its own course so it meets our needs." (STEP)

4.3 Affording Housing: Challenges to Housing First Model

This section highlights the challenges faced by service providers in being able to provide new housing or rapidly re-house existing clients in a climate of limited housing stock and allowances. Service providers talked extensively about the challenges they face in the delivery of programs. In particular, interviewees talked at length about the number

of units that are accessible to Housing First service providers and their clients, as well as the available funds for participants who may feel financially limited in terms of having funds left over for daily living expenses. For the majority of clients, Ontario Works (OW) or Ontario Disability Support Program (ODSP) is the major source of funding for rental units, but for some finding affordable housing that is within the budget of one or both of the government assisted programs can be difficult.

4.3.1 The Struggle with Suitable Housing - "They can afford housing, but little else"

Like many other social services, the success of supportive housing programs depends on adequate and sustainable funding. The three programs that participated in this research, the London CAReS, STEP Home and Transitions 2 Homes rely extensively on external funding in order for individuals to remain successfully housed and supported. In the Province of Ontario, the two major sources of funds for chronically homeless individuals are Ontario Works (OW) and Ontario Disability Support Fund (ODSP). These two provincially provided subsidized incomes are the main source of funding for individuals who require assisted housing. Funding structures vary for various clients and in many cases OW is the only source of funding for some individuals. While governments may consider financial assistance such as OW to be sufficient, many service providers expressed concerns regarding finding suitable housing for participants within a limited OW budget. Service providers also expressed concerns regarding the lack of additional funds many have after paying for rent.

One means of alleviating the strain on affordable housing is through a municipally provided rent supplement. However, rent supplements are given only to those eligible for

OW and such individuals typically only receive approximately $500-$600 monthly through that program. Receiving the extra funds through a housing supplement can mean the difference between housed and not housed. Commenting on the issue of funding for clients, one of the service providers noted that:

> “Well, right now success can depend on the subsidy that’s available to assist people. If you’re on OW and you’re getting $500 a month, where are you going to get a place? Unless it’s a really shady one-bedroom rooming house with an absentee landlord… sometimes there’s no water, it can be really bad. So I think the subsidy is the biggest thing right now.” (T2H5).

Several other service providers echoed similar views on the challenges associated with trying to keep people successfully housed on limited funds, as illustrated below:

> “The housing allowance is strictly put on the rent. We used to have $250 but we don’t have those anymore so we have a $200 housing allowance. It isn’t strictly with that unit, so if the client loses that unit, the housing allowance doesn’t go away, it’s always there...but even then they make $565 a month on OW and we pay $200? There is still $400 rent we have to pay out of $565… it can be challenging.” (T2H4)

> “Somebody who is on OW dealing with housing, with Housing First, the housing allowance on the units that we find, the market rent value is way too much. Our housing allowances are only for people on OW. People who are on ODSP, the more expensive units are suitable for them because they have more income, with OW recipients, basically all their cheque is being taken away.” (T2H3)

> “People on OW, even if were looking independently for housing for them, OW gives them about $374 for shelter, for rent, and they can’t even rent a room for less than $400. Sometimes you’re renting a room from a very shady area with shady people or you have to deal with a slumlord. The unit can have bed bugs… they can kind of get stuck there.” (T2H1)

Trying to remain stably housed in a one-bedroom bachelor apartment can be a challenge when you have less than $200 to cover all living expenses. To ease the strain on clients, service providers search for other potential funding sources, such as ODSP, if they only have OW:

> "The first thing that I want to do is look at [his or her] income because OW does not provide enough money for someone to live off adequately. I look to see if they are eligible for ODSP. That is one of the first things that I would do with somebody because ODSP is for people who are not likely to be working again, you can apply for ODSP with addiction as your main issue or your main disability. 99% of the people have mental health issues that were never addressed, so that's the first thing I try to do. Getting them on ODSP. When they have it, it's amazing. When somebody goes from 100$ extra a month to 300$ it makes a big difference on how successful they can be at maintaining their housing." (LC3)

Many municipalities only allocate a limited budget to assist the homeless through rent supplements to keep them stably housed. Being able to provide rental assistance can make a big difference in keeping someone housed, as was previously mentioned by the service providers above. Two services providers described their city's effort at providing rental assistance in the following words:

> "In terms of creating a tenancy that would be sustainable, the city has agreed to implement a rent supplement that broadens the range of choice. What we like is the relationship with certain property groups that have agreed to participate, so it limits where somebody can live. It would be similar to somebody in social assistance saying 'oh I want to live in that mansion' but you know that's not realistic…It limits the choices they have and the housing that we get typically will help people on OW but because they get the least amount of income they might not have as much choice as someone on ODSP for example who might be able to find housing outside of the program. If they've got ODSP there is more flexibility and we can kind of look at what they want but for OW sometimes it's more limited." (LC1)

> "We take the parameters of where they're looking to live and why. It's not an assigned 'you have to live here' it's a matter of letting them know that in order to participate these are the areas that have supplement units, these are also the areas where we have informal relationships with landlords. It's really about branching out from the not for profit to the for profit world. We're just not there yet in terms of having like a web that's being cast all over the city. When you look at where we have been successful at finding rent supplements it's all four quadrants of the city, so in that sense, I think for just two years progress it's been pretty good." (LC2)

4.3.2 Lack of Housing Units - "There are always people wanting to participate, but sometimes there's just no housing"

As noted above, funding is a crucial element in Housing First programs. However, equally important is the availability of rental units in the market. Throughout the interviews, the service providers provided comments to demonstrate the inadequacy of housing stock as a major challenge. Among the challenges enumerated were: limited housing options, long waiting time to access new units, and unavailability of housing units. Indeed, all interviewees were unanimous on these challenges, and some talked passionately about it, as captured below:

> "Right now the most challenging issue is probably just housing options, because we are very limited in what we might have. Initially, we had all these bachelor and one-bedroom apartments that we could just give away. Now those options have been limited, the cost of rent is higher, and the amount of money we are getting is less." (T2H1)

> "So the government is saying, 'house people, house people' but where, you know? We have gone months with no housing. We keep meeting clients and they're saying 'I'm ready. I've got everything when am I going to get my place?' and we're like 'oh, we don't have anything right now.' We also get pressure from shelters who are saying 'this person needs to go' and we're saying, 'well we've got nothing.' It's so difficult because the shelter has pressure from the city to move people along, so they're saying to us 'this person's been here 200 days they need to go.' While we have to tell them 'we have no units available' or 'we have no housing allowances left'." (T2H5)

With such a limited number of suitable housing units, there are also challenges associated with participant's choice and having to wait for a client to find a suitable place to live:

> "To actually get housed right now? Depending on how many units we have the average wait is probably 2-3 months. It can be quicker depending on the units, if we have a lot of units… It's just the city's not giving us a whole lot right now." (T2H4)

> "We only have certain buildings that we deal with, so the options not always so big. Like when we get a new unit we say, 'well we've got a board' we will talk about who needs housing and we'll say, 'so and so is waiting, lets offer him this unit.' I don't walk around with a big suitcase full of keys eh? Westmount,

> Eastmount, no no…. its whatever's available right, and then they have the choice of that. If they don't want it, fine, well offer it to someone else. That person will just have to wait until something else comes up." (T2H2)

> "Well it is your choice if you want the unit or not, but it's what we have available. If we have something way at the west end and the client doesn't want to go there because it's too far from all the services then we're not going to put them there. We will say, 'ok, then you'll just have to wait until something comes up closer to where you want to be'; it's their choice." (T2H5)

Sometimes participants are not willing to wait or have already been waiting for so long they end up choosing from poor quality housing. One service provider commented on the poor quality of some of the housing offered through agency partnerships with housing providers. Due to the general lack of interest from private market renters, these housing providers have units in poor state of repair and are willing to deal with some of the challenges that come along with renting to the homeless population in order to reduce vacancies within their properties:

> "That's the requirement, [clients] have to be willing to go into one of those buildings and that's how the partnership came about, because nobody wanted to go into those buildings. They have a really bad reputation, really bad crime, a lot of drug use, [landlords] want to get more people living in there than are supported because no one else will take them." (LC3)

During the interviews, the service providers mentioned that they have seen over and over again situations where clients turn down rental units because of poor physical state, mismanagement or neglect from landlords or property owners. The challenge of finding affordable and suitable housing is not exclusive to participants of Housing First programs. One service provider, recognizing the push by municipalities to offer Housing First services throughout all community agencies, saw it as not essential to successfully house more people facing homelessness:

> "I think that a distinction should be made between Housing First with support and just creating more affordable housing for people. If we just had more affordable

> housing and more accessibility to it then you wouldn't need everyone to have a Housing First program." (LC5)

Many others expressed similar concerns in regard to simply addressing the need to increase affordable housing to meet the needs of those at-risk of homelessness or the transitionally homeless. These concerns will be further discussed in later chapters.

4.4 Understanding the Needs of Participants

Many service providers stressed the difficulty of putting participants in housing without first addressing underlying issues, when they knew some individuals just were not suitable or would create challenges. These issues are more generally related to issues stemming from mental health concerns and addictions. As discussed in Chapter 2, Housing First is centred on the idea that in order to keep someone out of homelessness, providing housing sets the foundations for the process of recovery to begin. The assumption is that, once housed, other issues can then be addressed, such as addictions or mental health, because the individual no longer has to worry about being stably housed. Some of the findings mentioned below counteract that belief.

4.4.1 Clients Housing Readiness

Among the service providers who took part in the interviews, many discussed the unsuitability of Housing First Model for some individuals. Service providers at Transitions to Homes (T2H), who especially expressed this concern, believe that some participants may not be housing ready, have sufficient life skills or willingness to take responsibility towards aspects of the program. One of the basic tenets of the Housing

First philosophy is that housing is a basic human right. Some front line workers operating under the Housing First umbrella believe that while housing chronically homeless individuals sounds good in theory, not everyone is in a suitable position to be effectively housed. As illustrative comments, one service provider observed that:

> "I think it's up to the individual to kind of figure out what works for them. I would never necessarily deny someone housing but I also understand that they may not be ready or they may not be reliable enough. They may just not be in a place where being housed is going to work." (T2H1).

Another said:

> "It's good that [participants] have this program but I don't like it because we are taking people, especially the chronically homeless, out of their environment and putting them into a home. Instead of gradually building them up it's just sabotaging them. Some of them have had experiences where they have sustained housing; they've stayed in housing and been stable. But for someone whose life is just on the streets, they have no life skills whatsoever, they're not willing to change their addiction. But because they think, 'oh, here's a program that I can take advantage of, let's do it'. Then you're setting them up for failure because they'll get in and they'll just totally sabotage and trash the place." (T2H3).

Other service providers, while still recognizing the success of the programs for the majority of the people housed, expressed similar views in terms of clients' respect towards the supplied units, and the challenge of keeping some people housed: Two of the service providers discussed this viewpoint below:

> "Don't get me wrong, there are some people who really want [to be stably housed], and we have had success stories. Like we have 90% that have maintained housing after a year. So there's positive stuff, but the little things still become magnified…. The program tells me, house the hardest to house first, that's their mandate, so that's who you're going to grab. The guy laying in the gutter over there, you think you're going to give him a unit and all of sudden he's going to start putting flowers in his house? No. He's going to take what he did outside and bring it inside. All his friends are going to be coming and throwing rocks at his window, next thing you know we have to find him a new unit and the relationship with that superintendent or landlord is over... So it's definitely a minority. But the minority affects the majority. It's like the 80/20 rule right? 80%

> of your business is for 20% of your clients, so 80% of my issues are from 20% of my clients." (T2H2)

> "I think that there are certain limitations in terms of how successful somebody could be after a multitude of attempts at finding them different housing with that intensive support. Even with the community being involved, I think certain people are still at place in their lives where it's really difficult to maintain tenancy and to really experience stability." (LC1)

Service providers seemed to feel the constraints associated with having to follow a program's mandate or mission statement without fully believing in its implementation. When asked the amount of time it usually takes to find a new client housing and to start the program, they were not definite about the time frame. To quote one service provider:

> "A few months, three months, maybe six months, it's frustrating because the client wants housing but sometimes you look at the situation they're in, sometimes housing is not going to work for them right away. It could be that they're so addicted to whatever, that we have to work with them, to send them to a treatment centre and see how they do and when they come out of the treatment then we will reassess. We don't want to set people up to fail. We want to make sure they're ready when we move them into housing. I know the HF model says house the person first then deal with their issues, right? But when you're on a frontline position and you've seen what some of the issues are, you know it's very difficult to just throw somebody into a place when they have so much stuff going on that has yet to be dealt with. Sometimes when you put them in a place and they're still dealing with those issues you might lose track of them or they might not want to see you anymore and then the problems are still there." (T2H5)

Even though HF has no preconditions on the part of participants, some service providers still stress the challenge of knowing which participants are "reliable" or "ready" for housing, as demonstrated below:

> "We've housed some people that I never thought they would be able to be on their own, yet they've done wonderfully. It makes you think, 'what happened?' On the other hand, we've housed people that I'm telling you, I never thought would be a problem or things would have gone that bad. Some, you just never see it coming." (T2H5)

While still only a minority of participants, those who create the most challenges for service providers can hurt relationships with landlords and property managers for future clients associated with the program.

4.4.2 Understanding the Intricacies of Participants

Working with participants with such diverse and varied personalities, suffering from a range of concurrent disorders, changes the ways in which various service providers chose to implement or operationalize a program based on past interactions and experiences. Some service providers mentioned giving different levels of service depending on preconceived notions about how clients will act. Past experiences can lead to a range of techniques and approaches in dealing with a participant's issues and concerns, which can be both valuable and harmful. Experience can allow for a more seamless and fluid relationship between service provider and participant but it can also lead to conflicts and challenges if someone is too set in their ways, or cannot distance themselves from biases. Outlining the range of responses and attitudes towards participants and the approaches to dealing with them can provide insights into a service provider's personal approaches to addressing clients' needs as well as some of the overall limitations and strengths of HF programming.

Understanding the lifestyles of the chronically homeless can be hard for someone who is unfamiliar with the effects of mental health, addictions and poverty. As was mentioned in 4.4.1, it can also be challenging to predict who will and who will not be suitable for a Housing First program. Understanding how to keep people housed is an issue that all agencies face and is not exclusive to Housing First programs. The quotes below provide examples of the different issues faced by the service providers:

> "We saw a lot of people that were homeless for so long and every winter we would wonder, is this guy going to make it? When the program came into place, we saw a lot of people housed after years of being on the street, after years of being transient from here to here to here… when we have case conferences with the city every other week, it involves all the shelters and the people we end up talking about have been in the shelter for so long. We talk about the same people over and over again. It just seems like no matter what the shelter tries to do it's the same people that we talk about. What do we do with those people?" (T2H5)

> "It's easy to write people off, even when you're in a position of being an advocate and providing supports for them. Conceptually, it seems like such a far reaching idea that they would be able to do "normal" things like cook meals for themselves, pay their bills, and sit down and watch TV. There's a lot of people that if you look back at when we identified them through street outreach, compared to where they are a year later, you're like, 'man that's an incredible journey that all they needed was that piece of the puzzle, a place to call their own'. It's likely the ease and comfort that comes with not being in survival mode every single day and able to think about what they wanted. I don't think anybody really wants to experience homelessness." (LC1)

Although the service providers were aware of the daily lives of homeless individuals, many have never experienced homelessness firsthand. Service providers try to make sense of why HF works for some and not others, and explanations for participant difficulties ranged significantly. When asked about some of the potential reasons someone might be unable to remain housed, one service provider had this to say,

> "Sometimes people have led chaos their whole life, all they know is chaos, so when things start going well for them, they don't know what to do. They don't know how to react, they think, 'I better, ahhhh, pull the fire alarm, or boot my window out, just to get some chaos in my life again because that makes me comfortable'. People tell us their anxiety is extremely high because they're alone now. Their whole life's been shelters, incarceration; there's always been someone around them. Guys fight and attack each other, its chaos, but it's what they know. Now you take them to something they don't know, they'll sit in there…, won't even buy a bed sometimes, just sit in their room. Well once the chaos starts to creep in it leads to eviction, and then they get back into shelters and think 'I'm no good that's where I should be'."…. (T2H2)

Not all participants success and failures revolve around their "lives of chaos", as described by the previous service provider, but a variety of other challenges were

mentioned that can lead to an individual having challenges with housing. These challenges range from:

Stigma:

> "You place somebody somewhere, you provide them with intensive support, you support the landlord and the property group, you provide them with the rec and leisure support, you do as much as you can… They're still faced with a lot of the same stigmas they faced when they were on the street, they engage in a lot of activities that people find are morally questionable." (LC1)

Lack of engagement:

> "In the past they've gone from shelters to transitioning to housing and that's a significant change that their life is going through they shut down and don't want to engage." (LC4)

Access to addictions services:

> "The challenge that I'm finding is that it's really hard to connect my guys with services in order to help them deal with their addictions, because I'm not really knowledgeable in that." (T2H3).

Mental health:

> "Mental health is so huge right? Many participants can't always process information like you or I can. Like for you and I something so miniscule we just brush off, but for somebody else it's monumental because that one mini thing is on top of 600 other mini things. They get to a point where they can't cope anymore." (T2H2)

Problems with authority:

> "There are definitely individuals like that everywhere, right?... and sometimes it works for them and sometimes it doesn't. My belief overall is, if you have an authoritative view over a client you're not going to be successful because a lot of these guys are marginalized and have problems with authority to begin with." (T2H1).

> "Some people can't, no matter what you do, they're just not satisfied. They're just not happy and they expect everything from you or the program. There's only so much we can do? Some people, no matter what you do for them, just won't

> cooperate… Maybe their troubled with authority or something? No matter what the program, whether it's us or someone else he would do the same." (T2H4)

Issues of trust, both in terms of trust towards service providers and their peers, were also repeatedly mentioned, as illustrated below:

> "When you're dealing with people on the street for a long time they're really untrusting, building that trust is key. It's convincing them that they're going to be housed and we can support you. Selling people on the fact that we're going to put you in a house and we're going to work with you. In the past it's been 'we're going to put you in a house and leave. You got your housing, so good luck to you' It's hard selling participants on the idea that we'll be there to support them however long they need us." (LC3).

As well as clients just not wanting assistance,

> "But the main challenge seems to be keeping people housed who aren't overly interested in being participants in the program. So the idea of them being more of a participant, rather than a client is that they can work to set out goals for themselves. They can work with housing stability towards those goals, but if you have people who are just looking for a key to an apartment and sign onto a lease and have the worker leave them alone then that makes it pretty challenging to support them and keep them housed." (LC5).

Even with all the different challenges, service providers still find ways to make it work and successfully house people who are willing participants of a Housing First program. Being innovative and creative with clients was one technique that was used to help with particularly difficult clients, as explained below:

> "We've had people that have been difficult to deal with. I mean very 'VERY' difficult, but we just need to be creative and find a different way of supporting them." (T2H5)

One of the major principles of the Housing First philosophy is individualized and person driven supports. Each client has varying needs and challenges and being flexible to accommodate those needs, can be an essential tool in a service providers skill set. In the

following section approaches to addressing participants, community members and how each service provider approaches difficult aspects of their job will be examined.

4.5 The Importance of Relationships

One of the questions asked in the interviews was "What do you believe is the most challenging aspect of service delivery with your program?" In response, many of those challenges revolved around interpersonal relationships. During the interviews service providers mentioned that the vast majority of the clients needed to address particular personal issues, usually involving addictions or mental health in order to remain effectively housed. As was shown in 4.4, participants have varying internal conflicts, and generally they need to be dealt with at the individual level. Addressing conflicts at the individual level is just as important as addressing and strengthening relationships participants have with others. In many cases this starts with the relationships created with HF service providers. Without having a strong relationship between service provider and participant, being able to create more meaningful outside relationships, such as those with housing providers and community agencies can be challenging.

This section (4.4) outlines some of the challenges service providers face in creating those meaningful relationships in their day-to-day interactions with participants, housing providers as well as service providers from other agencies within the community. Service providers recognized the importance these relationships have for a participant's success in housing and that many factors in the implementation and operation of services can hinge on these relationships.

4.5.1 Service Provider Approaches to Dealing with Clients

Service providers understand that not every client will be cooperative and willing to participate and engage in the services provided by their HF agencies. Based on prior experience and peer-to-peer mentoring, service providers recognize that relationships with different participants require varying levels of support and assistance. By building successful relationships with clients, and recognizing the need for empathy and mutual respect, the ease of putting supports in place throughout implementation and operation can greatly improve. Unfortunately, as mentioned in previous sections, some participants can be more difficult and not every client gives the same level of respect towards service providers from HF programs or partnering agencies. This in turn, can hurt both parties.

> "I think it depends on the person involved right? If someone is well known in the community and is somewhat liked by the community, then they are usually well attended to. On the other hand, someone who is really challenging to deal with and really abrasive and rubs everyone the wrong way, there are few people who are going to be involved." (LC5)

> "…the support level is not the same as somebody else who is willing to talk to you and work with you and meet with you continuously. I mean nobody wants to be called names all the time and continuously wait for someone who never shows up." (T2H2)

When asked whether they had their own approach/technique to dealing with clients, outside of that recommended by their agency, interviewees offered a range of insight into specific approaches to dealing with clients and strengthening relationships, but for the most part these insights centered on the theme of respect. To illustrate, some of the service providers made the following observations:

> "I mean 'I'm going to treat you with utmost respect and I expect the same'. Understanding that there are challenges that they're facing and vice versa. Honesty is a big piece and I know as the rapport grows and that relationship builds, even someone's IV drug use can be open for conversation and that's not

> typically a conversation they've wanted to have. Eventually they realize that those conversations are just benefiting them and I think they realize that we're ultimately there to support them and see that they're successful." (LC4)

> "It takes a while to get some respect from some of them; sometimes it takes a couple of years… I expect them to respect me, respect the program, respect the units that they've been given and I don't expect them to destroy what we've given them… what they have is costly for us and taxpayers, you've got to respect that. Some of them do but some of them don't." (T2H4)

> "I have my own approach, and basically I'm dealing with people who are very street smart and know the system a lot better than I do. If you treat people with respect you get respect back in return. I'm not there to mother anybody. Again, they know a lot more than I do and I trust that they know themselves better than I do. We work from a 'client centred approach'. It's about their needs what they want, not me telling them what they need to do." (LC3)

Respect is given and received in many ways but prior experience with addiction, homelessness, and poverty can open the door to deeper understanding and mutual respect and empathy between service providers and clients:

> "I understand what they're going through because I've been there myself. I deal with them the same way I deal with anyone else, I don't judge them, I'm not here to judge them. I'm here to help them. I understand what their needs are when they need something, I know if they really need it …." (T2H4)

For the most part, service providers do not have, first-hand, experience dealing with issues related to homelessness and extreme poverty. In these situations, reflection in order to have a deeper understanding of clients and the issues pertaining to homelessness can be beneficial when trying to relate to clients, as well as having realistic expectations for them. One service provider, when commenting on participants missing multiple meetings, had this to say.

> "You also have to think about what kind of barriers they're dealing with. Could be that they were stoned, intoxicated, which happens a lot... But you also have to think that sometimes people have brain injuries that are undiagnosed, they don't remember. Whatever issues they're dealing with, our expectation of our clients

> sometimes has to be very minimal because you have to know who you're working with, and you know people are out there for a reason. You have to try to see it from their point of view." (T2H5)

Understanding things from a participant's point of view can be difficult for service providers but they also have first-hand experience working daily with participants and generally have a greater insight into their needs and concerns than the general public. One service provider commented on the challenge of trying to explain a program like Housing First to someone from the public who has never interacted with someone from the homeless population and who had difficulties understanding the merits of providing housing assistance to someone with an active addiction:

> "We have a lot of folks who have been dealing with chronic alcoholism for 40 years before we showed up. With this offer to support them with the next phase of their life, realistically I don't see where that would fit in to say 'ok, no more of this.' Cutting down and reducing is always a strategy that they're receptive to and interested in engaging with their worker, having conversations about how do I decrease or at least maintain [consumption patterns] and recognizing that you have the responsibility of a tenancy and there's certain things that you need to sort of honour in that." (LC1)

In commenting about the more challenging aspect of service delivery, service providers mentioned dealing with another person's stresses and conflicts can have an effect on their own long-term health and longevity. Being able to separate work from daily living, as well as not internalizing "clients failures" as your own, are two important aspects of service provider self-care that were identified by some of the interviewees. Also, addressing burnout and the need to separate your work life from your home life was another way service providers managed personal mental health. Staff turnover, caused by burnout was identified as a major barrier to a clients' continued success. Without

addressing personal challenges and stressors in work-life balance, it can lead to service provider burnout and a loss of valuable and successful relationships with some clients.

> "Turnover kills clients because they get attached to somebody. They're finally opening up and now you're gone and you put him with someone else, he doesn't have the same personality and the guy doesn't connect right away. So now the client just distances himself and becomes lost out in the public again." (T2H2)

Another service provider talked about the need to teach staff not to own "client's failures", and recognize their role as a facilitator to clients, not enablers:

> "We try very hard to teach staff not to own client's failures and to take on client's issues personally, because it has happened a lot. The case managers feel like if this doesn't work out or maybe I didn't do my job then it's my fault. Let your client take on their personal responsibility. That's why we have the client centred approach, we're there to direct them and we're not there to do the work for them." (T2H5)

This idea was echoed by another service provider in recognizing the active role they play as facilitators to clients not simply passive participants in client driven supports.

> "Being that facilitator, making sure that they're making informed decisions. It's about understanding, what my intention or what my work is. Why am I working with this individual and remaining focused on that. When we're talking about CAReS, our housing workers are there to focus on housing and housing related matters. If I'm going to engage with you assertively on focusing on those issues that are related to your housing because this is why I'm here, this is what I've intended to do with you. Also, that's where my expertise is and to think that I'm an expert in other areas is naive... when you're looking at Housing First it's really about keeping it focused to housing, to components related to their housing and insuring that you have an active role. You're not a passive participant to this person's life right, you are quite active in the care and support and direction of that care. You are there to help with crisis individuals may have but it should always focus around housing." (LC2)

Understanding the client's needs is central to effectively providing services to participants in any Housing First program. Acting as an active participant, playing a central role in the care and supports of clients, while still allowing for client driven goals

and supports is what service providers believe achieve the most effective and sustained results.

4.5.2 Relationships with Housing Providers

One of the most important external relationships that HF programs have is with landlords, property managers and owners. For the purpose of this chapter they will be referred to as housing providers. Making sure agencies find housing and clients retain that housing, involves strong relationships built with housing providers.

> “If you have good relationships with landlords then you have access to housing stock and they understand the needs of the people that we support. They also know that those tenants are coming with supports so they are more likely to rent to them because they have a relationship with us. They know that we’re not going to let them deal with clients on their own who might be beyond their scope of being able to deal with them.” (STEP)

Enveloped in every Housing First program are supports that are provided for housing providers by a housing worker specifically assigned to help their needs. Housing workers do not directly deal with clients; instead, they act as a liaison to housing providers and the tenant and their case manager. Housing workers mainly deal with issues that arise in relation to the tenancy, finding new housing, as well as making sure property managers understand all aspects of the program. Housing providers are important members of any HF team and are pivotal to the success of any program. As one interviewee mentioned, there were pros and cons to starting a new Housing First program and trying to find housing providers willing to participate:

> “There were some pros and cons to nobody really knowing us when it came to the housing piece in 2011. The pro was that we had a blank slate to work with landlords, so we could only build on those relationships. The con was that nobody knew who we were, so they were like, ‘what is London CAReS?’ ‘I don’t know what this program is, what are you all about? You want to house homeless people and you want to use my housing stock? What the heck are you talking about?’ It

> takes some time to gain that momentum when you're starting from such a foundational level ...it can be challenging." (LC2)

Even if a program has been in place for a long time, it can be challenging when trying to convince housing providers to participate in a program when they have little to no experience dealing with homeless individuals, and may only be familiar with some of the stereotypes associated with homeless persons:

> "A lot of property owners are afraid because of our clients, some of them do cause issues, and they don't want their building to turn into, whatever. So they will not jump on board, even though there is incentive from the city, they won't do it." (T2H5)

One concern expressed by service providers was that they were finding that some housing providers already involved with the program were having difficulty with certain tenants and no longer wanted to be a part of the program. This concern has resulted in a situation whereby a large portion of potential housing stock was being lost. The following comments provided by service providers captured this concern:

> "You end up having landlords having one bad experience and then they get a sour taste in their mouth. The landlords in London are a pretty close knit group, especially the larger property managers. They all talk like a "sewing circle" and when something bad happens, everyone gets to know about it. So if you have too many of these negative experiences and have too many detractors from the program and maybe a bit of bad press, it makes our job much more challenging to find new housing." (LC5)

> "Because our name is attached to tenants, any problems that arise with that tenant, depending on how bad that situation is, [housing providers] back out. We've had a lot of that happen." (T2H3)

> "So the government's saying to me "you've got to house [the chronically and episodically homeless] first." Well eventually were not going to have anywhere to put people because [housing providers] are going to say "you know what, I can't have these guys breaking my building." (T2H2)

> "Thankfully, not all tenancies end in a crisis and eviction, and some 'tenants love their place and will never move out'."(T2H1)

Service providers work for the clients and try to meet as many of their needs as possible. Some have daily interactions and advocate for them on regular basis but have limited contact with housing providers. Outside of the housing workers, many service providers do not frequently interact with landlords or superintendents, and find it challenging to address issues related to a client's tenancy with such little interaction. Although frustrating, many try to justify lack of participation by trying to see the housing providers point of view:

> "Everybody's got a little bit of a heart. But when you start taking away and affecting people's money, that heart goes away… It can take 6-7 months to get a guy evicted maybe even longer. So this guy can go six months without paying your rent. There's lost revenue, frustration, maybe a lost superintendent, maybe a loss of good tenants around this person who can't deal with it anymore. It's one big money thing and if you're a property manager for these bigger companies, at the end of the year you get a bonus, your bonus is based on tenancy, pest control, damages, etc. Well when a tenant starts effecting your bonus, you know what, he or she may agree that the program's a great thing 'but it's not for me'." (T2H2)

> "You might be homeless for years and you might have street friends that are still experiencing homelessness and when they start living with you, that's an issue for some landlords. That increased activity is going on in your unit, without having an understanding of what poverty kind of is and what trauma is and what substance use actually is and how it impacts the person over time. I get it, that's not there role. They are 'a for profit' enterprise, "I want to get my rent paid by the first few days of the month and maybe I want to do some social goods but you guys do the social work and I'll do the land-lording"... so that dynamic is difficult at times." (LC1)

Keeping property managers and owners onboard is a major part of the overall success of HF as they provide the needed housing stock for prospective clients. Some of the interviewees offered recommendations on how to minimize the further loss of housing providers, in order to have access to more housing.

> "We've got to educate the owners and property managers to be completely on board with what possibly could be happening in the program. We can't go in and

> sell a bill of goods that's not true… Be honest and transparent, let them make the choice right then. There's some people that will say, "you know what, OK. I've got some places that are difficult to rent." Unfortunately, that's why some of our places are not the most desirable; they're not getting rented by the regular public so why not get a program to rent them? "I can deal with some issues, I'm not on site, plus my money is guaranteed. The city gives me some money, his payment comes directly from OW", that can be a selling feature for many people." (T2H2)

> "We learn early on that not every landlord is up for this project so how do we strategically go after the ones that tend to have sympathy for the cause, but also those landlords that we know that are responsible landlords but perhaps have challenges with vacancy rates? We well say "we'll ensure that those units never go vacant and you will never lose money on them because we will always have someone to house them there." Some Landlords are really receptive to that and say, "I'm willing to roll with the punches that come with learning how to provide adequate housing to this population, if you're telling me you're going to help me with my vacancy rates in certain buildings." It becomes a very symbiotic relationship." (LC2)

That "symbiotic relationship" can provide the most secure and continued housing for new clients looking to be housed. If housing providers are having vacancy issues, HF programs can secure continuous guaranteed income with supports. Not all housing providers are going to be able to deal with some of the challenges faced with housing a more difficult population, but being able to provide supports and assistance when needed can keep them from leaving and perhaps convince other property managers to get on board.

4.5.3 Community Involvement, Collaboration and Resources

As discussed by one interviewee, changes in paradigm take a lot of effort.

> "...it's like trying to steer a ship right, it takes a lot to change its direction and to change its course." (LC2)

In order to effectively make such drastic changes to a communities homeless support structure, working with other agencies trying to achieve the same goals, getting homeless people off the street and housed, is essential to making system wide changes. In this sub-

section, an overview of interviewee's perceptions of the shortcomings facing increased community integration, collaboration, and cooperation for the most effective services is discussed.

Service providers understand that participants have a variety of needs that may be outside of their expertise. They also recognize that the most effective support can be achieved through increased community involvement and collaboration. Community involvement and supports comprised of involvement with sister agencies dealing with specific segments of the population (i.e. women's shelters, child and youth homelessness, seniors care or sex workers), emergency response services (i.e. Police, EMS, shelters), or addictions and health related issues are an intricate part of the overall system. Strong relationships with other agencies and community partners can minimize the stress related to providing successful services. Some of the interviewees commented on the need for increased awareness and involvement from different 'actors' in the community for more intensive and rapid responses to client needs.

> "From the community you would really want them to rally behind the idea that nobody in this community should be faced with chronic homelessness. Recognizing that it always may exist, but it should exist for a really short period of time and there should be a really articulated plan to get somebody out and back into housing. You would want the community to at least be in the know about the programs that are in place and be aware of the multitude of issues that tend to bring somebody into that experience such as poverty, trauma, and mental health and addictions, and not just assuming that it's always somebody's addiction or laziness... addressing all those kind of common stereotypes that perpetuate somebody's experience with homelessness." (LC1)

> "There is that perception in some communities and among some providers that Housing First is really primarily about putting people in housing and letting them go, but really the supports are central to the model as well. I mean that's really

> embedded into the Housing First philosophy and model and sometimes that gets misunderstood." (STEP)

Involvement and awareness from community partners is an important part of wrap-around services for effectively housing homeless individuals. Unfortunately, when there are difficulties collaborating with "older" agencies that work with different mindsets or approaches, challenges may arise. For one service provider, the current state of collaboration was referred to as a "competition for clients".

> "It seems like it's a competition for clients. Service providers compete for clients to justify your own existence right? ... Everybody competes, because if [an agency] stops getting clients, they think well maybe the government will pull the plug on them and they're out of work." (T2H2)

Dealing with the competing agencies who may not necessarily agree with the newer approach to services, can also be challenging. Two service providers from the City of London commented on the challenge of trying to work with some of the more longstanding agencies.

> "It can leave some resentment from community stakeholders that used to play a very significant role and are no longer having a direct involvement [in city programming]. [At the beginning] it was very much around rebuilding those relationships with those very relevant stakeholders because we knew that even though the relationship was strained there was too much overlap in our client population and in the work that we were doing that we needed to have a good working relationship with them moving forward. And having that strong community collaboration to make this project work. So it was a lot of rebuilding those relationships." (LC2)

> "They've been dealing with [these clients] for 30 years and there's probably a lot to gain from their perspective too. It's a matter of merging the two and finding ways to rejuvenate the people who have been doing it for 30 years to say "this is how we're going to start doing things, this is the intervention, this is how the supports are going to look and we would really love to hear your expertise to help support certain individuals." (LC1)

While the above service providers brought up local challenges they have faced, both still recognize what can happen when a community collaborates and starts a collective

conversation. For example, both went on to comment on the U.S. Housing First initiative, "100,000 Homes" campaign and the successes it has had.

> "I think that its takes a community and I think that the communities that are really doing well and on the cutting edge of sort of ending chronic homelessness have bonded together and pulled all their resources and said "this is what we're doing, let's keep our eyes are on the prize." Like the 100,000 Homes campaign in the U.S. that just surpassed its goal. When you see the things that communities can do when they put their resources together and their minds towards something, it's really astonishing and fiscally it's way more responsible too. I mean the taxpayers should love that idea." (LC1)

> "I think when you see the growing popularity of Housing First it gets easier to kind of inform a community and have them come around to it? We see even in the U.S. it's a very growing thing to where it's actually being talked about in mainstream media. The 100,000 homes is a HUGE campaign right? That's actually getting people that are not connected to this sector at all, talking about homelessness and thinking about effective strategies... My mom for example, who knows nothing about homelessness, she can understand and relate to that campaign and it makes sense to her and she wants to get behind that." (LC2)

Service providers also commented extensively on the need for integrating community emergency services and the importance of those relationships as a means of "taking some of the burden" off emergency services' workers. When asked about any "pushback" from some of the agencies in the community who may not necessarily agree with the Housing First approach, the interviewee has this to say.

> "I think that there's probably a common perception that social services and police might not get along and see eye to eye, but I think what we saw was that there was enough overlap that we could be of benefit to each other in a lot of these common situations that people who are homeless find themselves in.
> There wasn't a whole lot of pushback because we committed to very clear objectives, we knew that we wanted to be able to respond to police 24 hours, and we knew that we only want to respond to those that are most vulnerable and most frequently contacted. That involves a time commitment of being able to deliver on it every single time, in our case within 30 minutes, where we would be on scene prepared with a response and solving the problem. That way we can alleviate the pressure on police always being the default. I think what happened is police saw results and saw [the program] as a benefit or an asset pretty early on and they saw

> the constant and effective response from both sides that they kept using it and kept informing other officers around the benefit of using it." (LC2)

4.6 Summarizing the Opinions of Service Providers on the HF Approach

In previous sections of this chapter specific challenges and concerns regarding the successful implementation and operation of HF supportive services from the point of view of service providers were discussed. Up to this point, based on what was found in this study, one might conclude that service providers have overall a negative opinion towards the HF approach. Unanimously, service providers agreed that, overall, HF is the most effective way of housing the most people. Although there can be challenges with a few individuals, service providers perceived HF as more effective than previous approaches to housing and supports. In the following sections, service providers comment on specific aspect of the HF model and critically reflect on what aspect of the program needs to be improved as well as respond to the overall benefits of the approach.

4.6.1 Some Doubts Regarding HF

It is worth mentioning again that although there are a variety of negative responses towards specific aspects of Housing First programs, all service providers still recognized Housing First as a valuable and necessary approach to housing the chronically homeless under the umbrella of homeless support services. Housing the chronically and episodically homeless can be challenging in respect to changing a person's lifestyle when it becomes an intrinsic part of a person's day-to-day existence. Getting them out of their normal cycle of emergency shelter accommodation and emergency supports into housing

can be a challenge. One major criticism service providers had towards HF was that they didn't know how to deal with the extreme loneliness some faced when housed.

> "Housing first basically is to get people out of the shelters or off the street, into their own place, and continue to support them in maintaining housing. It's all nice and good and it sounds very good on paper but when you're on the frontline it's not that simple. Somebody who's been homeless for so long and all of a sudden they get put into a place, that's challenging. If the barriers that they're facing haven't been dealt with it can explode. We see people die because they're so lonely. They're so used to being around people all the time. You know if somebody's been from one shelter to another for the past 6 years and then all of a sudden someone goes "ok here, this is your place." When we leave they are so alone and we've seen people go into depression." (T2H5)

Another criticism of the Housing First model that seemed to cause some frustration with a few service providers in Hamilton's T2H program was regarding the amount of times one tenant should be re-housed.

> "They give clients too many chances. A lot of clients will tear the place apart and get evicted so we house them again and they do the same things and get evicted again. They'll start dealing in a landlord's house, it causes major problems, they get evicted and we house them again. I think there should be a limit of how many times we help them, but we continuously help them." (T2H3)

> "Sometimes we try but the person doesn't want to be housed. That's their lifestyle, no matter what you do. I mean there are people that we've housed, for example one person we've housed like 4 times in different places. This one didn't work for him this time, ok let's try here, and within a month, well this one didn't work, let's try here. This is all while you've got other people who have been waiting and saying, "why do you keep moving this person around?" But that's part of the HF model, you don't give up on the person. If the person screws up it doesn't mean that it's the end, we just have to try to find something that's a fit for them." (T2H5)

These service providers disagreed with the amount of times some individuals get re-housed, expressing their frustrations in regards to the missed opportunities in housing that other clients could have had. As well as the tainted relationships with housing providers that was a result of the continual re-housing of the most challenging clients.

Another criticism addressed by service providers was the strict requirements for participation in the program. HF programs only house those who have a proven track record of extended stays in shelter, ignoring those who may spend their nights on the streets or couch surfing.

> "The number of days that people qualify for the program became an issue and is still an issue because sometimes people will say "I'm on the street, I'm sleeping on a couch how come you can't help me?" "We'll we only take referrals from the shelters." "Do I need to go into the shelter before you can help me?" Unfortunately yes, and it's very difficult to say that to people. I know that's going to change but even the change that is coming will be difficult to implement because even now they are looking at 180 days instead of 30 days and they're looking at the episodically homeless, so now we would have to track people episodically you know and that can be difficult." (T2H5)

Although this was a criticism of the current program towards its referral process, this service provider also commented on the limited number of housing options available even for the chronically homeless. That is, although it would be nice to serve an increased proportion of the population, without the required housing stock, housing more people outside of the chronically homeless just isn't possible.

Another criticism of HF was addressing the broader issue of poverty and providing solutions, perhaps it can be seen as another solution, which fails to solve a more foundational problem.

> "Housing First is really good for providing housing, stabilizing individuals and allowing for the opportunity for greater health outcomes. And I would say it allows for greater opportunity to exit out of living in poverty but it's also very limited I think in the idea of having concrete solutions to how we address people's poverty." (LC2)

Service providers did comment on a variety of limitations to their program but still identified them as challenges that can be overcome by increased investment in time,

effort and innovation. One way to overcome some of the challenges was in understanding that Housing First programs should be part of a collaborative system with other agencies approaches and areas of expertise.

> "I think that if everyone did Housing First there would be a tremendous amount of problems with over saturation and "ghettoization" of certain communities. You would have a bunch of workers at different agencies drawing from the same group of landlords that are only willing to work with agencies doing Housing First, so you would end up with a bunch of people living in the exact same building and landlords who aren't overly concerned with working on those buildings or any types of issues. If you have everyone doing Housing First, if everyone focuses their money on the exact same goal, then other things will start to slide in the community and you would start seeing bigger gaps in mental health supports." (LC5)

Another criticism recognized by a few service providers in the STEP Home focus group was that while trying to keep with Housing First fidelity standards, they still believed in the need for specific, locally relevant, adjustments.

> "We think that we are already doing many elements of a Pathway approach and I think that what we're hoping through this process is to better understand the strengths of that approach. What can we do with our existing resources and perhaps some limited new resources to strengthen our existing model, like what elements would we bring and how would things be organized." (STEP)

> "It's interesting hearing more about the diversity of different ways that communities are "operationalizing" Housing First, because I think it's really easy to get information about At Home/Chez Soi, it's easy to get information about sort of the classic Pathways model, but as we all know, lots of communities have been working on developing local solutions for a long time. What do those different localized responses look like and how can they help us also think about that balance of finding locally relevant and locally, organically evolved programs and supports when it comes to implementing Housing First type approaches." (STEP)

Service providers understood that each community has different needs, funding structures, housing stock and homeless populations. Figuring out how to effectively utilize the Housing First philosophy to provide consumer-choice and self-determination

to clients, based on locally relevant responses and experiences, was considered important to program success as a whole. Whereas traditional approaches would determine what was the best course of action for each individual along the continuum of services, Housing First opens the door to myriad approaches and perspectives not only in achieving consumer goals but also the goals of the communities at large.

4.6.2 Service Providers Verdict on Housing First Model - "Overall, Housing First is the Best Approach"

Many of the following responses reflect the final question asked in the service provider interviews, "What would you recommend to other service providers or supportive housing programs trying to transition to a HF approach?" The responses in this chapter may not reflect perceived unanimous opinion from all interviewees that there will always be a need for other approaches to ending homelessness, but that is in fact the case. No service provider believed that Housing First was the "end all, be all" to supportive services but they believed it to be, overall, the best current approach to housing and supports. Many service providers also see the need for supports and collaboration from other agencies, as well as support from the community at large, in order to continue to provide stable housing for their participants.

> "It's a way for people to do what they feel they need to do and self-medicate while having a roof over their head. Just the psychology and the empowerment of having a place to call home for people is a huge advantage. I think also the community integration is important. So there's a lot of stigmatization that comes from being a shelter resident but when you have your own place and you're a member of the community, then you can start to integrate in different ways and participate as a community member."(LC5)

Being able to actively participate in the community without having to feel the negative effects of stigmatization is something many people who have never dealt with poverty

take for granted. It can be especially difficult for someone within the homeless population facing increased stigmatization and discrimination based on being labelled “homeless.”

> “I mean, people are getting housed and are living the way that they deserve to live. It’s quite clear that individuals, and some are obviously people that are experiencing homelessness, require an ongoing support to be successful. Whether it is diagnosed or undiagnosed mental health concerns or addiction issues they’re within an apartment that they deserve to be in. They’re being provided that ongoing support and I mean even the stigma that’s being attached to the population we work with. Whether it is in the hospital or in the community, even at the grocery store! I mean when I was a housing stability worker taking somebody grocery shopping for the first time in ten years, not knowing where to go within the store and just the looks and how uncomfortable he must have felt. I can only imagine how he was feeling because he hasn’t had to accomplish this task of daily living that you and I do every single day. So that makes me feel as if that’s a clear benefit to being able to implement this approach.” (LC4)

Understanding the root cause of stigma and how to address it within communities was something that was also addressed by a service provider.

> “It’s a solvable thing right? I mean we’re really particular and cognizant of the vernacular that we use. So if somebody experiencing homelessness… that doesn’t follow them throughout their lives, like eye color might or hair colour or being left handed might. I mean those are fluid things potentially and it’s really about reshaping and refocusing on what going on here. It’s not rocket science; if somebody is without a home they need a home. But you can’t just house them and leave. Housing First is never without that support piece, you would never just find them housing and say, "James I helped you get a place, here is your apartment, here is your keys”, and away we go. That’s irresponsible when you look at who your target audience is.” (LC1)

In many cases, there are individual success stories from participants who are selected for the program that many assumed would never be successfully housed.

> “I think it is a pretty tremendous thing to acknowledge when we’re thinking about who are target demographic is. They’re 100% of our caseload, participants on our caseload are participants that most people in this community said were not ‘housable’! They have been living in shelters or on the streets for years so it’s a pretty staggering outcome when you look at that. It speaks to the kind of value of doing things differently, doing things perhaps more on a one on one basis or

> really putting the additional measures in supporting people in a way more intensive way than what's been available before." (LC2)

A similar idea was expressed in regards to other agencies in the community. That is, while some other agencies may have been sceptical at first, their attitudes seem to have been changing over time, as illustrated in the comment below.

> "If you were to kind of poll them now, there might be some people who might suggest that their lives and service deliveries have become a bit more manageable because the people that we've offered an intervention to are no longer seen as weights on the system and now their thinking is different. You can say literature and research as much as you want and somebody could choose to read that and engage with it or not, but on the local level, when all of a sudden you've seen (participant) for ten years at that park, drunk, defecating himself, getting picked up by police, calling the ambulance to the emergency room, back to the park, day in and day out, to being housed, creating a grocery list, buying his own groceries, listening to music, looking to re-engage with his family, whatever! That really pulls at your heartstring right?" (LC1).

One of the major advantages of Housing First as a philosophy and as a program is the change that can be seen in individuals once housed. Some of the challenges that these individuals have faced and the barriers they need to overcome can lead some with little to no faith in some client's ability to achieve housing stability, to have a change of heart. Service providers adamant about the program stressed the need to see housing as a right and not something that should be earned.

> "I think first and foremost, the principal of Housing First is about saying housing is a right. That's principle number 1! Anybody that says that someone can start to address there substance use issues while residing in a shelter, I'm going to guess has never lived in an emergency shelter, or doesn't have a good enough idea of what life is like in an emergency shelter. Has never tried to exit a shelter without having drugs offered to them, has never been in a situation where having such anxiety or stress about trying to make it through the day that you can start to think about your challenges with substance abuse, or your struggles with your own mental illness. When you're trying to live one moment at a time as a result of never having a home you know it gets pretty challenging thinking about long term

> goals, and I think Housing First and in looking at housing as a right, give people that opportunity to start thinking beyond just the here and now." (LC2)

Understanding the day-to-day struggles someone might face and the supports that are needed to address those struggles can be daunting for someone who lacks first-hand experience. As mentioned in the previous quote, giving someone the opportunity to start thinking beyond their present situation was echoed by other service providers.

> "I think that the main idea is that if someone is housed then they have an opportunity to look at other socioeconomic factors in their life and they can start to improve on their life and start to get integrated back into a community." (LC5)

More importantly, participants can finally reach a point where they can have a sense of pride in their lives.

> "They're in their own house, that's the biggest benefit the people have. The right and freedom to be in their own house… You can see the pride that they have because it may have been ten years since they've been in a home and that can be a powerful thing." (LC3)

As well, having the time to think about what the client's needs are and guide the individual in a way that best meets those needs, was expressed by one service provider with past experience working out of a shelter setting.

> "I do find that it is more effective as a caseworker to be doing what I do now versus doing what I did in the shelter… The biggest difference now as a caseworker with London CAReS, I have 8 people that I work intensively with. I see most of them daily or at least two or three times a week and it's about really specific measurable goals that we are working on together that are driven by them and not by the fact that they have to leave shelter in 30 days or that ODSP or OW requires this or that documentation. It's about what they need." (LC3)

Getting the chronically and episodically homeless out of shelters is the main objective of the HF approach. HF reduces the amount of nightly stays at shelters, it

reduces the overall costs to the system and it gets people out of a cycle of daily struggles associated with living on the street or in an emergency crisis situation. As many service providers mentioned, HF allows for the most people to be reached.

4.7 Summary

Housing the most frequent and longstanding individuals who currently or have accessed emergency shelters, provides an opportunity for healing and an opportunity for these individuals to set attainable goals for the future. Understanding service providers' perceptions of the Housing First model to supportive housing, now the "gold standard" to supportive housing, provides an opportunity for program evolution and increases in overall effectiveness of housing and support systems. Housing First can be used as a starting point for specialized, individual responses for each community, which best suits their needs, but having a collaborative approach to the integration and co-operation between community agencies can achieve the most successful outcomes.

This chapter has outlined many different challenges associated with housing the chronically homeless population as well as documented some of the perceived limitations and advantages of Housing First programs from the perspective of front line staff. The documentation of personal experiences in this study can allow policy makers and program directors in these communities to get a sense of some of the common themes associated with Housing First programs in their specific locale. These experiences can also offer insight into thinking about the most suitable responses for other communities and how that might lead to the evolution of services in their respective community or municipality.

Table 4.1: Summary of Major Themes (Service Provider Perspectives)

Theme	Characteristics
The Transition from TF to HF	- Service providers recognize the increased push by governments towards HF programs - Old approaches to housing the homeless were simply not working as intended - Believed in the need for a change in paradigm regarding housing and supports for those facing chronic and episodic homelessness - Expressed challenges regarding "pushback" from other agencies in the community
Housing	- Lack of housing stock - Lack housing options - Need for more rent supplements - Need for increased financial assistance to broaden range of choice in housing - Ontario Works only does not provide sufficient funding
Participant Needs	- Favour "consumer-based" supports, but still believe some clients are not "housing ready" - Recognized the need to understand the daily challenges faced by participants in order to limit rehousing - Understanding that not every participant wants to be housed
Relationships Building	- Strong relationships with participants builds rapport and increases housing success - The importance of mutual respect between service providers and participants - Relationships with housing providers of utmost importance - "Housing providers are not social workers" - Need to limit "silo" operations within communities - Recognized the need for more collaboration and information sharing between organizations
Overall Opinions Regarding HF	- Overall recognized HF as the best approach to housing the most individuals facing homelessness - Believed a select few participants would have better success in housing with previous approaches, such as TF - Offering other options might limit the negative side effects associated with continually rehousing participants

CHAPTER 5: RESULTS

TENANTS' PERSPECTIVES OF THE HOUSING FIRST MODEL

5.1 Introduction

This chapter explores the perspectives of participants of Housing First model in the City of London. In line with the objectives, this chapter will identify some of the perceived benefits and limitations of HF according to participants of the program as well as help in determining whether HF is the most effective approach to supportive services by documenting the experiences of London CAReS (LC) participants. To address this objective the chapter draws on empirical data collected by the Lawson Health Research Institute (LHRI) in 2013 and 2014.This is a large-scale study that aims to assess and evaluate the London CAReS program. Three open-ended interviews were explored with 65 participants of the LC program over a period of 1 year. The questions explored by the LHRI study were largely consistent with the objectives of this study and therefore the transcripts of responses from all three interviews were utilized for this chapter. As with Chapter 4, interviewees had the opportunity to express concerns that they believed were of importance through open-ended interview questioning, responses from the questions from the three interviews were compiled and an analysis was conducted. The goal of this chapter is to summarize the findings from the open-ended interview transcript of London CAReS participants to explore their perspectives and experiences with HF and in so doing, discover whether similarities or differences exist between tenants' perceptions and

those of service providers found in Chapter 4. Attention was paid ensuring that the views of a variety of respondents were expressed, as well as ensuring that the opinions and perceptions of respondents were from different interviews during the data collection process.

This chapter is arranged into 3 major sections. Section 1 deals with perceived health outcomes of LC participants both before and after participation with LC. This is followed by section 2, which deals with perceived housing outcomes and satisfaction of LC participants both before and after participation with LC. Finally, section three deals with participant's opinions and positive and negative experiences in their involvement with the LC program.

5.2 Perceived Health Outcomes

One major barrier to individuals remaining housed is their overall quality of health. If a participant's major concern is his or her health, challenges regarding keeping that individual housed and keeping them from repeated use of emergency medical services might exist. Repeated emergency service use is commonly seen with many chronically and episodically homeless individuals and the reduction of that use was one of the major reasons for the evolution of HF programs. The meaning of "Health" in the case of the open-ended interview questions conducted for this research is open for interpretation on the part of the interviewee and can represent a variety of connotations pertaining to physical, mental or interpersonal "health", depending on each individual's interpretation. Table 5.1 represents the three interviews that were conducted with the same 65 individuals over a period of one year. Participants commented on their

perception of their overall health at three different points in time: (1) at the commencement of the research; (2) six months after the initial interview, and (3) 12 months after the initial interview. Table 5.1 represents their perceived health outcomes after involvement with London CAReS.

Table 5.1: Perceived Change in Health Outcomes Before and After Involvement with London CAReS

	1	**2**	**3**
Better (+)	46	47	41
The Same (=)	11	15	12
Worse (-)	8	3	3
Total Participants	65	65	56

In order to have a clear understanding of the overall trends in health outcomes, the questions asked were, "Do you think your health has changed for the better or worse since you've been involved with CAReS? Do you feel better about things now?" As shown in the Table 5.1, the majority of responses focused on improvement in each individual's wellbeing. Findings were fairly consistent over the three periods and do not represent any significant change in opinion about perceived health. Overall, with reference to participants' perceived improvement in their health outcomes, some even go so far as to thank LC for saving their life.

> "Better. It has turned my life around 100%. They have given me a lot of encouragement and a home. I could never have done this by myself. They help me with furniture, money, and my medications. It was a 180-degree turn in my life. In fact, I owe my life to London CAReS. With their intervention, I still slip once in a while, but it is nowhere near how it was before. The support from the workers…

> They saved my life. I have had several friends die from drinking since I moved in here." (CAReS-1)

> "It's better. I've been taken more seriously, it's better because I've been getting the help and I'm on medication. Now I'm willing to ask for help. The support network is there and it's compassionate so I feel better." (CAReS-1).

One reason for the improved health outcomes mentioned by some of the participants involved was having a network of supports to help them achieve some sense of stability, to work towards a healthier lifestyle. One of the participants was explicit about this issue.

> "London CAReS has advocated for me in situations where I've been in because of my addiction, and people in health care actually listen now. They also encourage me to get myself checked out when I feel I need to. They just all around encourage me to care more about myself." (CAReS-3)

In some cases, just having someone to talk to was a way participants felt they could alleviate some of the stress involved with such a huge lifestyle change from being chronically homeless to successfully being housed. As some of the participants noted,

> "In the beginning they took me grocery shopping and to doctor's appointments. If I ever had the urge to drink, or if I was having issues and needed to talk to someone, London CAReS was always there. I was always able to talk to them. I have had a rough life and they are a big part of my life." (CAReS-3)

> "Better because actually you're involved with them and they are going to appointments with you. You feel encouraged and feel like someone cares. It's nice to have someone to talk to. Especially if you're single, they are fun to talk to and pretty punctual." (CAReS-1)

> "In a time when you're basically all alone, it helped a lot knowing there was a support group out there who cares about me. I had family but it just wasn't the same." (CAReS - 2)

Without that support and daily person-to-person interaction housing an individual can make them feel lonely, isolated and may lead to serious health repercussions. One of the few participants who had negative health outcomes noted,

> “My biggest problem is being alone. It’s been like that since I was 15 or 16. I hate it here. I am scared of living alone. So I think it's worse (than shelters or living on the street). I've considered suicide but I won't do it because I'm Catholic.”(CAReS-1)

Providing supports and having networks for communication and advocacy for Housing First participants can make a world of difference, especially with those who do not know how to go about making the necessary life changes and need additional guidance, as captured in the comments below.

> “It's positive, they were the ones, one day last winter, I was walking down the street, I was limping (from chronic pain in foot), I remember two London CAReS guys were behind me. When you're on the streets, you have your bag on your back, and I was hobbling along, and London CAReS was right behind me. They said “you know what, you're getting worse.” I kind of teared-up, they pushed me into 'enough is enough', let's start looking for a place. I started renting, I met a nice guy, I've stopped doing drugs and I’ve put on weight. London CAReS looked at me, and said let's start looking for a place, and I wanted a place, but I didn't know how to go about it.” (CAReS-3)

Many times, something as simple as helping an individual fill out forms or providing transportation to appointments, can aid a participant in improving their health outcomes. These individuals may not have the capacity to do so by themselves. As such, the intensive support provided by Housing First service providers helps participants with their overall quality of health. This in turn assists participants in successfully attaining housing and maintaining it permanently, providing that foundation for future life changes.

5.3 Housing Outcomes

As with the health outcomes outlined above, understanding participants' housing needs as well as their current level of housing satisfaction can help to determine whether HF is favored by participants of LC, and can help in discussing some of its benefits and limitations of the approach according to its participants. Determining participants' perceived housing outcomes was a major part of the open-ended interviews conducted by the LHRI study. Questions relating to housing needs were two-fold: (1) do participants believe their housing needs were being met before involvement with CAReS? (2) Do participants feel that their housing needs have been met since their involvement with CAReS? Participants in the study were asked to describe their state of housing before and after involvement with London CAReS through self-reporting.

Based on the first housing related question: How were your housing needs being met before involvement with London CAReS? Client's responses were categorized as either: "Not Being Met" (i.e. couch surfing, living rough, transient); "Institutionally Housed" (i.e. Shelters, Hostels or Jails); or "Content with Housing" (i.e. housed with family, spouse or by themselves). Table 5.2 below, represents participants' self-reported satisfaction with housing and all responses were categorized into three outcomes mentioned above. Some individuals may not have disclosed where or how they were being housed but simply responded with answers such as "Poorly" (CAReS-003x3), "Bad" (CAReS-004x3) or "I was homeless" (CAReS-041x3). In those cases, while the individuals could have potentially been "institutionally housed" through emergency shelters or in jail, there responses were simply added to the "Not Being Met" category.

Table 5.2: Participants Accommodation before Involvement with London CAReS

	1
Not Being Met	50
Institutionally Housed	12
Content with Housing	3
Total	65

As shown in Table 5.2, a vast majority of participants housing situation was either "not being met" or the individuals were being "institutionally housed" before their involvement with London CAReS. The assessment of past housing quality was followed by: "How are your housing needs being met since your involvement with London CAReS?" Table 5.3 shows participants' responses to current housing outcomes and needs as "Better", "The Same", or "Worse".

Table 5.3: Improvements in Participants' Housing Situation after Involvement with London CAReS

	1	**2**	**3**
Better (+)	53	57	46
The Same (=)	9	6	9
Worse (-)	3	2	1
Total Participants	65	65	56

In comparing Tables 5.2 and 5.3, the majority of participants believed that their housing needs were not being met before involvement with LC, but were being met after

involvement. For many participants, being stably housed provided the groundwork for a complete lifestyle change, as was expressed by some participants below.

> “It overwhelms me all the support from London CAReS. Their help changed my life. Like this morning, a London CAReS worker helped me do my groceries, gave me my medications and helped me set up doctor's appointments. I just consider myself one of the luckiest people. Since I got involved with London CAReS I severed all my relationships with the people who I used to drink with all the time.” (CAReS-1)

> “It has changed for the better. Overall, changed my life for the better, I wouldn't be here without them.” (CAReS - 2)

Not all participants are in the position to make complete lifestyle changes in order to live sufficiently without assistance and ultimately secure an employment. But for most participants, simple things such as providing the essentials for living including furniture or the occasional food donation is what keeps them from re-entering the shelter system or life on the streets:

> “I still don't always have food, but that's okay. They helped me find a place and furniture. When they got donations from Kellogs, they gave me two bags of cereal. But I don't usually ask for help unless I haven't eaten in 1 or 2 days.” (CAReS-3)

> “They encouraged me to get this place. They helped me set up. They offered to go with me to apply to Ontario Disability Support Program. They were with me to go see different places. They are always there. They offered to be there as an advocate if I needed it. They worked with me to find a place based on what I needed. Gave me a list of resources. Told me where I could go get stuff, for example, they told me where I can get a bed.” (CAReS-3)

Advocacy from service providers on behalf of participants is a big part of a successful Housing First program and was mentioned by participants as a beneficial aspect of working with CAReS.

> “(London CAReS) helped me realize I did not need to let people into my home to use drugs. They taught me how to say no. They advocated for me by speaking to the landlord I have now, and they help me so that I will not continue my bad track

> record of past evictions. They helped me set up all the finances and complete the paperwork I needed for my apartment." (CAReS-3)

> "Great, now I can't ever see myself not being housed permanently and stable. Basically, they set it up for me. They found my new apartment. If there's a noise complaint, or something, they'll advocate for me, where as if it was just me doing it, I may not have as much luck." (CAReS-2)

As mentioned in Chapter 4, many landlords and property managers are unwilling to provide some of their available units to people who struggle with homelessness. Common stereotypes about homeless individuals such as drug addiction, incarceration or mental health problems, can act as deterrents to many housing providers in supplying available units to those struggling with homelessness. When an agency and its service providers are able to assist and support an individual with housing there is a greater chance that more housing opportunities will be provided to them. According to a participant who took part in the interview,

> "When I was being taken care of by London CAReS, they brought me to a selection of places to look at. Unity Project helped me out with the first and last month's rent, but [name of London CAReS worker] brought me around to look at several places for me to choose. They helped me move the stuff I was able to bring from my old house to the new apartment, and they were able to rent a delivery truck to help me with the move. They were really helpful. They really help people to take that big first step. I mean with the appearance of a homeless person, it's almost impossible for someone with worn out clothes and looking so dirty and scruffy, to go around and find a place. As well, with no transportation, even with a bus pass it's not possible to go around looking for apartments. The landlords are a lot easier to convince if they know you're with London CAReS, because they don't have to worry about any issues with the apartment, because they know they can always go to them. London CAReS is kind of like your guarantor. So many people who received support from London CAReS are eternally grateful. They actually treat people who are homeless like human beings." (CAReS-3)

There are many different aspects involved with Housing First programs other than just providing housing. Without the extensive supports, advocacy and assistance with basic necessities provided by programs like LC, many individuals would not be able to

retain their housing for such extended periods of time as is seen in studies looking at housing outcomes such as AH/CS. In the following section, some of the positive and negative experiences associated with participation in LC are discussed in order to gauge the major advantages and limitations of London CAReS—based on the experiences of its participants.

5.4 Participants Perspectives of London CAReS and the Housing First Approach

Part of the open interview questioning in the LHRI study involved asking participants to comment on both their positive and negative experiences associated with involvement with London CAReS. Many of the responses revolved around interpersonal relationships with staff as well as the support and advocacy participants received from their workers and other service providers, under the umbrella of London CAReS. Overwhelmingly the responses were positive and participant's involvement with LC was perceived as meaningful. A few participants expressed concerns regarding LC but the vast majority was positive, both positive and negative responses will now be discussed in greater detail.

5.4.1 Positive Responses to Supportive Services and Interpersonal Relationships

As shown in Tables 5.1 and 5.3 above, the vast majority of participants who were interviewed believed that since becoming involved with LC they have had improved health conditions and housing outcomes. The exact reason for improved health and housing outcomes may be difficult to pinpoint but it appears to stem from beneficial interpersonal relationships between the participants and LC staff. Indeed many

interviewees attributed the supports provided by their caseworkers or other outreach workers and case managers within the program to be a major reason why they remained successfully housed. Several participants alluded to the good support services they often received from the service providers.

> "They give me support, emotional support. I don't know how to live sober after living on the streets for so long. So any questions that I have, they give me guidance and advice. They help me with managing money. They got me utensils so I can cook my own meals. Rather than blowing my money when I'm drunk, which I have done, it goes directly to my landlord. London CAReS arranged all of that." (CAReS-3)
>
> "Just the all-around support, 24 hours a day, 7 days a week, I don't think there isn't anything I couldn't ask for when it comes to needing help. And the workers, they definitely go outside their job description." (CAReS-3)
>
> "They helped us (participant and his dad) get a place right away. It is hard to find a place. We would not have been able to afford it. I do not know how they (London CAReS workers) did it, but they pulled some strings I guess." (CAReS-1)
>
> "All of the caseworkers that I've been involved with have been very approachable, and things seem to get done quicker. For example, I was having trouble getting things fixed here (apartment), I mentioned it to London CAReS and things got fixed within a couple of weeks. They seem to have an influence where the average person wouldn't." (CAReS - 2)
>
> "I went from out of jail to being on the street to getting involved with them and getting a place. They make it easier for me to see, like a step by step to see how to get better." (CAReS-1)

Having someone to help individuals 24/7 manage a system with a variety of coexisting agencies with different operating structures and areas of focus can make an otherwise confusing and overwhelming situation become relatively straight forward and simple. Being involved with LC opens up opportunities that might not have previously existed without their help. For example, landlords were seen as more willing to offer housing to those individuals who previously may have been overlooked.

5.4.2 Assertive Engagement: Navigating an Intimidating System

Many participants need someone to help navigate a confusing system in order to remain housed. HF programs like LC offer extensive supports and assistance in order to keep individuals housed. Many participants attributed their housing success to a supportive staff, as illustrated in the comments below.

> "Just always having someone who is responsible, to talk to, because my family are all addicts; so they're all positive role models, they're always there for me when I go to jail, when I get released from hospital. They always stick by me." (CAReS-3)

> "I first started to work with the out-reach workers on the street. They were there to listen to me when I was down, to cheer me up, which is the best thing anyone can ask for, I think." (CAReS-2)

> "We went to see the apartment, my CAReS worker came for a visit, it was reassuring that they were there. I didn't feel as isolated. Especially with PTSD and alcoholism. I felt there was someone there to help me with the transition after my wife left me. It was very beneficial and definitely lifesaving. They helped me even when I didn't ask for it." (CAReS-1)

Service provider's assistance to the participants provides encouragement and helps them deal with uncertainties in their lives. Sometimes case managers act as advocates for their participants to a variety of different agencies, both governmental and non-profit, as well as to individuals within the private sector such as housing providers. Without advocacy from agencies like London CAReS on behalf of some participants, finding housing or being able to access specific services within the community can be difficult and intimidating.

> "Them being an advocate for me. Sometimes it's hard to approach people, places and things. I'm going to court, and she's been there every single time, that makes me feel more comfortable. I can bounce things off of her, and she can give me suggestions, not telling me what to do, but you can try this and this." (CAReS-3)

5.4.3 Trust and Empathy

Another benefit regarding supports mentioned by the participants of London CAReS relates to compassionate and trusting relationships. For many participants, moving into a new home and making the transition out of homelessness can be a very lonely and a challenging experience. Having a case manager available to talk to ensures a smooth transition and rehabilitation from previously difficult life situation. To illustrate, two participants commented below.

> "They are always there for me when I need them. When I am stuck at the hospital, or even just when I needed someone to talk to. It was easy to become involved. They were right there as soon as I got out of the penitentiary. It was as if they were already involved with me before I was involved with them." (CAReS-3)
>
> "Just people listening, they take me seriously. They don't put me down for being poor, or label me." (CAReS-2)

In providing empathetic and compassionate services some of the participants found that they were finally able to "trust" again.

> "They help. They help me, they help a lot of people, you can trust them it's hard to trust people when you're on the streets, especially social agencies, but it took me a while to gain their trust because at first I wouldn't accept their help." (CAReS-3)
>
> "My self-esteem, hope, and sense of trust has increased…they helped me stay clean when I use, and also said they would help me get off that stuff." (CAReS-3)

Understanding that service providers are there to advocate on behalf of participants in order to achieve the participants' goals in attaining housing and deal with addictions or mental health concerns is one of the pillars of client-centered supports. For participants to get to the point of having a productive and trusting relationship with

service providers requires time and patience but most importantly, empathy. One program participant stated that,

> "The empathy of the whole organization. It doesn't matter who you speak to, you get the same level of concern. They don't babysit you, they'll help you with going to court, or housing, they'll take care of the big stuff, but you have to participate, it's not a free ride." (CAReS-3)

The most successful participants are the ones who are willing to participate and actively work towards their specific goals with their case managers. The best way to aid in managing and achieving those goals is for service providers to act as facilitators and not enablers for their clients.

5.5 Criticisms of London CAReS: The Voices of the Few

While the majority of responses involving health and housing outcomes for participants was positive, there were still a few individuals who expressed concerns around London CAReS programming and staff. These concerns revolved around two major issues: (1) Interpersonal relationships with service providers and (2) time management or availability of service providers. When asked whether participants felt they experienced setbacks in the implementation of services and working with LC the majority felt they experienced no challenges. Some participants in the study did express concerns regarding the level of services they received and it is important that their views are also documented.

In regards to lack of access or availability of LC service providers a few participants expressed frustrations, as seen in the comments below.

> "They're not always there when you need them. Like yesterday I was supposed to look at a place and it didn't happen. I know they have other clients but they aren't always there during the hard times." (CAReS-3)

> "Sometimes it can be difficult to meet with my housing worker, if someone else is in a crisis, then our appointment might get cancelled. I understand that emergencies are more important, but a lot of times I don't really say that there's anything wrong, they just won't show up." (CAReS-3)

> "Just maybe if I'm in need of something and they have something else going on, I think their caseload is way too high, and it's difficult for them to meet everyone's needs, and that's frustrating." (CAReS-3)

Understanding why some participants may feel like their needs are never or rarely met, may involve individuals with more intensive needs than the average participant. This can lead to situations in which service providers may not able to meet on a daily basis, perhaps due to the needs of others on their caseloads, or potentially a lack of communication on the part of the service provider.

Another issue addressed by participants was the difficulty in being able to establish a meaningful relationship with their case manager due to negative past experiences with other agencies or staff. Most of the responses centered on issues of "trust", as can be seen by the comments below.

> "It wasn't easy because I didn't trust them at first. There are a few agencies out there that say they're going to help but they don't. London CAReS had to prove themselves to me." (CAReS-3)

> "When they first came out I didn't really like them, it took a while for me to trust them." (CAReS-2)

While some participants did find it challenging to establish meaningful relationships with their service providers early on in the program, most eventually improved those relationships and were able to adequately work with service providers.

5.6 Summary

Overall the majority of respondents had no challenges associated with their involvement with London CAReS. Some interviewees even went so far as to offer praise to the organization or acknowledgement of specific staff when asked about potentially negative experiences. It was also found that overall satisfaction with programming barely changed over the period of the study and any changes that did exist seemed to be associated with a decline in participation in the study.

This chapter sought further understanding of participants overall perceived health and housing outcomes of their involvement with London CAReS. Insights into both positive and negative responses to interpersonal relationships with service providers regarding such topics as advocacy and positive reinforcement, trust, empathy, the importance of healthy relationships and the availability of staff were also outlined. In looking at some of the major accomplishments and challenges participants faced in the implementation and operation of services, comparisons with these responses and those found with service provider interviews will provide insight into some of the personal and structural changes that may need to take place for the most efficient future programming.

Table 5.4: Summary of Major Themes (Participant Perspectives)

Theme	Characteristics
Perceived Health Outcomes	- The majority of participants experienced improvements in health outcomes after involvement with London CAReS
Perceived Housing Outcomes	- An overwhelming majority of participants experienced improvements in housing outcomes after involvement with London CAReS
Positive Responses to London CAReS Involvement	- Supports from London CAReS workers was attributed to how successful individuals were at remaining permanently housed - The benefit of 24/7 outreach and supports - The importance of advocacy from service providers - The importance of building trust and empathy with service providers
Negative Responses to London CAReS Involvement	- A few expressed challenges regarding relationships with certain service providers - A few criticisms of the availability of service providers

CHAPTER 6

DISCUSSIONS AND CONCLUSIONS

6.1 Introduction

Housing First (HF) is widely considered “best-practice” in providing housing and supports for the chronically and episodically homeless (Goering et al., 2014; Aubry et al., 2015; Cohen, 2008, Waegemaker, Schiff, & Rook, 2012; Gaetz, Scott, & Gulliver, 2013). Increases in government funding for programs applying HF within their program mandate as well as from a philosophical standpoint, as outlined in the Homelessness Partnering Strategy (HPS) (Employment and Social Development Canada, 2015), has led to the changing environment of HF for many communities in their approach to addressing homelessness. To date, research pertaining to participants of HF programs has shown increases in housing retention rates (Tsemberis, 2010) as well as decreases in emergency service costs (Goering et al., 2014; Aubry et al., 2015). Although scholarly research on the perceptions and experiences of participants of HF programs has been relatively widespread, relatively little work has been done on service providers with the exception of Henwood et al. (2013) and Nelson et al. (2013). The goal of this thesis was to address this gap in the research by providing perspectives and documenting experiences of service providers within the context of three programs located in Southern Ontario. These three HF programs are at various stages of implementation and experience. Specifically, this thesis sought to:

1. Examine the perceptions of service providers on the major barriers to the successful implementation and operation of Housing First supportive services.
2. Investigate service provider and program participant perspectives on the benefits and limitations of Housing First approaches.
3. Assess the extent to which service providers agree that Housing First is the most effective approach to provide housing and supports for the chronically and episodically homeless.

This chapter is categorized into 3 major subsections. First, this chapter briefly summarizes the opinions and experiences of service providers and participants, as illustrated in Chapters 4 and 5. Second, recommendations towards the enhancement of services for chronic and episodic homeless persons, is outlined. Finally, conclusions and recommendation for future research is discussed.

6.2 Summary of Study Findings

Based on the information collected from the service providers and participants, overall, the majority of service providers and tenants agreed that HF is a viable approach to supportive housing. Service providers were more critical of certain aspects of the HF approach and philosophy but still recognized it as the most effective program to housing some of the most chronically homeless individuals. Many perceived challenges still exist and these will be discussed further in the following sections. In regards to participants of the London CAReS program, interviewees overwhelmingly agreed that their overall

health and housing outcomes after involvement with LC greatly improved. A few concerns were expressed with the program, but such views were in minority.

6.2.1 Perspectives of Service Providers

Overall the service providers agreed that there has been a shift from the traditional Treatment First approaches to the new HF philosophy. The foundation for that change stemmed from the deficiencies with previous approaches. Issues regarding poor housing retention rates, lack of success with old approaches, and visible increases in shelter and emergency service use, were some of the reasons for the shift towards HF. The successes found in studies surrounding best practice approaches such as PHF and AH/CS, have led to further implementation of HF programs across the country. Service providers who participated in the research recognized the government's push for a change in approach and also understood the importance of attempting something new in order to achieve better housing outcomes for their clients.

When asked questions regarding the changing environment of housing and supports, service providers reflected on the change within their respective communities and commented on some of the most difficult challenges associated with that change. While HF service providers agreed the HF philosophy was the best approach for housing the majority of participants, criticisms regarding a few clients, as well as the overall lack of responsiveness towards the implementation of HF from pre-existing community agencies was made clear. Comments specifically regarding "competition for clients" and "pushback" from sceptics within emergency shelter programs, which for the most part still use more Treatment First approaches, were also commonly discussed.

Challenges and criticisms regarding specific aspects of HF from the programs analyzed in this study also became apparent. One major challenge expressed by service providers was having housing available for prospective clients and the importance of housing allowances to broaden the range of choice in housing. Service providers expressed challenges in being able to find affordable housing for participants simply on OW, and in order to maintain the long term stability of housing, having financial assistance available was essential in keeping people housed. If supplements did not exist, service providers believed many participants would not have enough money left over for the basic necessities such as food or utilities. Other issues regarding housing that were discussed were the overall lack of housing and the poor state of housing for participants of HF programs.

Service providers also recognized the importance of past experience with other clients and expressed challenges in not being able to prioritize supports for their clients as choice of supports is purely up to each participant. While the core principal of HF is to provide immediate housing coupled with *consumer-based* supports, many service providers believed that participants may be in a state where housing might not be the best solution as it could lead to continued failure, and in effect, hinder the future success of participants' goals.

The importance of strong relationships between participants and service providers as well as between HF programs, housing providers and community agencies, was recognized as another integral part of any HF program. Service providers recognized the importance of mutual respect and empathy for building strong rapport with their clients. They also recognized the need for self-care in regards to their own mental health in

delaying or preventing “burn-out”. One of the most important relationships from the point of view of service providers was with landlords, property managers or superintendents. Without cultivating those important relationships many service providers expressed concern that current and future units would cease to exist without them.

Finally, overall views of the program were discussed, looking at the pre-existing issues and successes of the HF approach. On the one hand, issues surrounding participants’ loneliness, the limited reach of the program outside of the chronically and episodically homeless and frustration regarding the amount of times someone should be re-housed were brought to light. On the other hand, praises for the program were widespread and the overall appreciation towards HF was made clear. For example, service providers discussed success stories regarding participants remaining housed after years of unsuccessful attempts at housing. Even with continued disapproval from some community partners in being able to successfully house specific clients, after achieving permanent housing for those clients, it became apparent that some service providers from TF programs became less skeptical of HF.

Service providers also believed that being able to house some of the most challenging clients, who were continuously overlooked by many agencies in the community, shows the merits in continuing to establish HF in all communities.

6.2.2 Perspectives of HF Programs Participants

One of the objectives of this study was to unearth the views of LC program participants. Overall, perspectives of participants regarding housing and health outcomes before and after involvement with London CAReS was overwhelmingly positive as the

vast majority of participants found improvements in both housing and health outcomes, as shown in Figures 5.2 and 5.3.

In regards to opinions of the program, participants commented on the beneficial aspects of being involved with LC. Advancements were seen in their relationships with service providers in providing more opportunity for housing due to advocacy from staff, more of a willingness to trust in the system that had "previously failed them" and benefits from the assertive engagement and moral support provided by LC service providers. Of the negative experiences reflected by a few participants, expressions of frustration with the lack of availability of staff, and comments on the difficulty in establishing meaningful relationships - which others had attributed to their success - were the only two major areas of concern.

6.3 Putting Everything into Perspective: New Directions and Lessons Learned

In comparing results from chapters 4 and 5, it became apparent that opinions towards HF were overwhelmingly positive. Both service providers and participants considered HF to be more effective in achieving client-specific goals, compared to previous practices, and housing retention rates were much higher. Both the service providers and program participants agreed on the importance of establishing strong relationships and rapport between each other. Many attributed this aspect of service to be an integral part of initial, as well as continued success, in the implementation and operation of services. What also became clear was that the intricacies of operation and implementation of HF programs was poorly understood by participants. Participants received services through the guidance of their individual service providers but were unaware of the steps in receiving

that service, such as the acquisition of housing or financial assistance. Gratitude towards service providers and their advocacy for the participants' needs was outwardly expressed by a few, but the majority seemed to simply be satisfied with finally achieving permanent housing.

The major indications or cautions regarding the continued success of HF came from the point of view of service providers. Service providers who participated in the study had a range of experience and expertise, from less than one year's experience working with homeless populations to almost 18 years' experience. In the process of data collection, the most valuable insights into the challenges and advantages associated with the shift towards HF approaches were most apparent with the more seasoned service providers. While similarities regarding the perceptions of HF existed between all three programs, insights into the challenges each faced in effectively providing services seemed to vary based on establishment of the program.

STEP Home community partners, the most recent of the three programs included in this study, were just in the process of implementing a more Pathways to Housing First program model. Focus group discussion mostly revolved around the need for change from the old Treatment First approaches to HF. The need for change was due to the continued lack of success experienced with specific clients and the frustrations that were conveyed by some of the community partners in not being able to effectively house individuals. The STEP Home focus group also affirmed that the need for local relevant approaches and a progression or evolution of support to the ideal Pathways model would, in their mind, be the most preferred method to change moving forward. In the process of conducting the in-depth interviews, views regarding community pushback, lack of

approval, or uncertainties with the HF approach were more commonly discussed. Focus group discussion rarely touched on these issues, and when they did, discussion seemed to be brought back to focusing on the needs of participants. The potential for "groupthink" (Janis, 1982) within the focus group members could have been a potential cause for the change in subject, as discussion was generally led by a few individuals and did not equally represent all focus group participants.

Caution or vigilance for future success with the implementation and operation of service came from the in-depth interviews conducted with service providers from London CAReS (LC) and Transitions to Home (T2H). Consensus in determining the major perceived challenges with the two programs could not be made and while both recognized some of the same challenges, each had different opinions towards the significance of those challenges. The second most experienced program, LC, began its change in services towards a more housing focused approach in 2011. Of the three programs, LC currently most closely reflects the Pathways to Housing First approach established by Sam Tsemberis, as mentioned in chapter 3. Caseloads do not exceed a 1 to 10 ratio (except in certain situations such as a change in staff) and services follow an assertive community treatment (ACT) model as well as an intensive case management (ICM) model depending on the needs of the client. Challenges in the effectiveness in services were concerned with difficulties surrounding cooperation and collaboration with community partners. Support and cooperation with LC was mentioned in regards to some emergency service workers such as police and medical staff, but major challenges and disagreements seemed to surround emergency shelter staff and agencies. Service providers mentioned having experiences of hesitation, lack of cooperation and outright

disapproval from many shelter services in London. A few service providers expressed similar challenges from T2H, but LC staff was unanimous on this topic.

Delving into why disagreement existed between homeless services agencies in London was based on speculation, and a further understanding of the roots of those disagreements might be a topic of interest for future research. What was made clear was that confrontations towards service delivery for some clients did exist and in turn created challenges for all service providers in the LC program that participated in this study.

The biggest challenges expressed towards the effective delivery of service involved the T2H project. The T2H program, which operates out of Wesley Urban Ministries in Hamilton, was established in 2009 and was an evolution from the Hostels to Homes pilot project, which took place from 2007 to 2009. T2H has slight differences in its program model in that it simply uses ICM with caseloads sometimes exceeding 20 individuals. Access to medical, psychiatric or addictions services was said to be difficult and was not, at the time of interviews, part of T2H support teams. These services were part of T2H upon establishment but were eventually cut due to funding. Changes in the program to simply an ICM model with larger caseloads after the Hostels to Homes pilot project might be due, in part, to decisions surrounding its more longstanding history in Hamilton and the potential for the needs of the more chronically homeless individuals having mostly been addressed. The major difficulties addressed by T2H service providers revolved around the lack of housing stock, the affordability of housing and the challenges in accessing available housing. The longest existing of the three programs, T2H seems to have exhausted many of the potential avenues to find housing. As well, mention of completely tainted relationships with some major housing providers in Hamilton, who are

no longer willing to work with the program due to too many negative experiences working with challenging T2H participants, has also limited their choice in housing. All service providers involved with T2H commented on challenges dealing with housing providers. Challenges stemmed from either hesitation or outright refusal to participate due to such things as first hand-experience or word of mouth from other housing providers within the community sharing negative experiences with the T2H program. Two service providers from LC also mentioned this as a concern in London, but it was not to the extent expressed in Hamilton.

Another concern only addressed by LC and T2H service providers was regarding the complete removal or restriction of some of the most challenging clients from using the HF approach to service. Four individuals from T2H and one from LC believed that limiting the number of times someone could be housed or removing them from the program, in a sense reversing approaches and utilizing a Treatment First (TF) philosophy, would be more successful and beneficial to the future of the program and the success of future clients. Service providers recognized that the hesitation and lack of participation that existed with housing providers was due to the “failures” or “challenges” associated with few participants and did not represent the whole client base. While all service providers believed that HF benefits the most individuals, many still believed that the old approach to housing and supports, or TF, would be best for addressing the most challenging individuals. Justifications for reinstating past approaches involved the need to limit damages caused to the majority by the select few. This idea is in stark contrast to the overall belief of HF, that access to immediate housing should be a basic human right and no participant should be excluded from inclusion in the program. Service providers

also contend that the number of times some individuals can be allowed to re-house, should also be re-evaluated.

6.4 Contributions of the Present Research

A sea change has been witnessed in the response to housing and supports for the chronically and episodically homeless, from the TF model, emphasizing a linear progression in the implementation of services, to the HF model, emphasizing a person's right to housing and consumer based supports. Gaining insight in to the thoughts and voices of those who implement and experience HF on a daily basis can help bridge the gap between the policy makers and those who operate on the front-line. Based on the concerns and criticism addressed in this research, slight changes in the framework and philosophy of HF approaches in each of the programs studied, as well as other municipalities and regions in Canada, might lead to future policy evolutions and developments in homeless support services.

6.4.1 Policy Implications and Recommendations

Two major themes that emerged in this study were: housing inadequacies and the importance of social service collaboration. Relationships with housing providers and the overall availability of housing stock were seen as major barriers to the continued success of all HF programs outlined in this study. In terms of housing stock, a potential solution would be for municipalities to implement a mandatory requirement for all participating housing providers in HF programs to provide a guaranteed portion of all units to involved agencies. While this could lead to the potential for more access to units for clients, it could also have an inverse effect and lead to the diminishment of participation, as it

might act as a deterrent for new agencies to become involved. In order to limit the amount of existing housing providers withdrawing from the program, or limit sceptics from future involvement, some form of incentive might be required. This incentive would be on top of the already guaranteed rent from government financial assistance like OW or ODSP, as well as the guaranteed occupancy of housing providers' vacant units. This could take the form of an initial monetary incentive or tax break for property owners.

Further investment in overall affordable housing stock is also an avenue which should be explored by municipalities and is one of the key recommendation made by Gaetz, Gulliver and Richter (2014) in their latest editions of "The State of Homelessness in Canada: 2014". In Chapter 2, discussion surrounding the evolution of affordable housing in Canada and the dismantling of Canada's National Housing Strategy in the 1990's as well as the lack of investment in affordable housing over the past decades is attributed to the current affordable housing crisis in Canada (Walks, 2006; Mah, 2009; Pierre, 2007; Leone & Carroll, 2010; Londerville & Steele, 2014). A dedicated supply of affordable housing needs to be in place to meet the needs of the most intense users of emergency and homeless services. Regulation also needs to be in place to ensure that any new affordable housing is not misallocated to those with more housing options and resources. Expressing a similar view, Gaetz, Gulliver and Richter (2014, p. 51) argued that, "simply expanding the supply [of affordable housing] does not necessarily lead to housing homeless people as new supply can be easily absorbed by market demand elsewhere in the country. Unless specifically reserved for people exiting homelessness, individuals and families with more resources and greater access and who are less likely to face discrimination, will monopolize any new housing supply." Increased support for

housing providers was mentioned as an essential part of the future success of Housing First programs by service providers and should be considered an crucial aspect of the future development and evolution of programs moving forward.

Another major challenge faced by the HF programs in this study was the need for increased involvement with community partners in order to effectively achieve full “wrap-around” services for clients facing the most intensive needs. Poor housing retention and lack of respect towards units from some of the most difficult clients can lead to a deterioration in the relationships with housing providers and community partners and disadvantage the future stability of those relationships. By allowing for a range of support options, potentially enforced at the discretion of HF teams, it may lead to more stable housing for participants and reduce the need for continual re-housing (Wong, Filoromo, & Tennille, 2007; Tabol, Drebing, & Rosenheck, 2010). Having a range of supports available will require collaboration with a variety of community partners, willing to implement flexible solutions, with varying expertise. This belief was expressed by one service provider in London.

> “I don’t know why agencies can’t just collaborate and talk about what works well from the shelter model, what works well from the treatment model, and what works well from HF. Make something that works together! Why does it have to be so black and white? This whole population lives in grey, nothing is black and white with them but they’re expected to just conform and change with whatever the expectations are of the people who make the decisions.” (LC3)

Offering a range of choice might be able to reduce the duplication of services, increase overall housing and health outcomes and lead to a more effective management of government funds. More lateral collaboration between homeless service agencies might also satisfy the discontent faced by some HF service providers towards the lack of

success in HF programs, faced by a few individuals. This discontent might also be addressed by reinforcing the need for communities to more closely follow fidelity standards outlined by MHCC's Housing First Toolkit (Polvere et al., 2014). As was found in some previous research (Turner, 2014), while some programs may label services "Housing First" they may not in fact follow stringent guidelines outlined by PHF and MHCC. Other adaptations, which may appease some of the discontent expressed by service providers, might be through referrals of select clients to TF agencies (based on consensus from HF teams), forcing treatment when HF approaches continuously fail, although this would represent an outright contradiction to the HF philosphy.

This need for collaboration is similar to what is outlined in the Canadian governments HPS, supporting "comprehensive community planning processes involving officials from all levels of government, community stakeholders, and the private and voluntary sectors" (Employment and Social Development Canada, 2014). This would make the collection of data regarding total number of homeless individuals through information-sharing much more possible. The need for collaboration with different community agencies for the most effective supports is consistent with the call for more "system-planning approach" to services (Austen & Pauly, 2012; CAEH, 2013; Greenburg & Rosenheck, 2010; Hambrick & Rog, 2000; Turner, 2014; Mares, Greenburg, & Rosenheck, 2008; Nebelkopf & Wright, 2011).

6.4.2 Academic Contributions

Within the academic literature, this study is the first of its kind to compare the perceptions of HF service providers from separate agencies at different points in time of their program development. Comparing different agencies with varying level of expertise

and experience has led to further scope in understanding the needs of municipalities seeking to implement or further improve HF approaches within their respective communities. This research has also given further insight into implementation and operational challenges faced by specific HF agencies in Canada. Comparing the findings of this study to more widely known projects, such as AH/CS, show consistencies in the need for further investment in affordable housing (Goering et al., 2014) but differences in regards to discussions surrounding the importance of building strong relationships with housing providers and challenges surrounding collaboration within other agencies is lacking. As well, outside of the extensive AH/CS study, comparisons of different communities utilizing HF are few. AH/CS compared 5 different HF programs from 5 different provinces and regions with different areas of focus. Unfortunately, within the context of Ontario, little academic research outside of Toronto has been completed, and this study seeks to fill that gap. No study comparing different HF programs within one province has been conducted and this study is a valuable addition to the academic knowledge pertaining to HF approaches being implemented other than AH/CS pilot projects.

6.5 Conclusions

This research study explored the perceptions of service providers and participants involved with HF programs, in the evolution of the implementation and operation of successful HF approaches in three Southern Ontario Cities. Research findings indicate that investment in more affordable housing as well as striving to achieve a more integrative and collaborative system to address the needs of those facing homelessness

could lead to further improvements in the housing and health outcomes found in studies like the MHCC's At Home/Chez Soi and those involving the Pathways to Housing approach in the U.S. An almost complete change to a Housing First philosophy and supportive services has been achieved in Canada. A better understanding of the causes of homelessness as well as the changes that need to take place to eliminate it are clear. Co-operation and participation from all levels of government as well as from key players within the non-profit and for-profit industries can make eliminating homelessness, especially for the chronically and episodically homeless, possible. Considerations for other subgroups of the homeless population, such as youth, seniors and families should also be discussed in the development and expansion of future HF programs. Disposing of the dilapidated supports of the past, and addressing the needs of the most intense users of emergency and homeless supports can open the door for the broadening of scope for many currently unable to access Housing First programs.

6.5.1 Recommendations for Future Research

Based on this study's findings, further research involving the perceptions of TF service providers towards the changing dynamic of housing and supports, to HF approaches, would provide further insight into the reasons for disagreements or outright disapproval towards HF. Experiences of TF service providers could also highlight past successes of the more established programs, which should not be forgotten in the changing environment of homeless supports. As well, documenting some of the perceptions and experiences surrounding emergency service workers such as law enforcement and EMS and ER medical emergency service providers might also provide

additional insight into the amelioration towards the effective collaboration of wrap around community supports.

Most importantly, an examination of the perceptions of housing providers surrounding challenges working with Housing First programs and some of the concerns and limitations in its scope of service could provide insights into ways in which programs should operate and be structured in the future. These insights could educate and inform service providers and Housing First programs of the challenges faced by housing providers, potentially limiting future disengagement on the part of housing providers such as landlords, property managers and superintendents.

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APPENDICES

Appendix A: Service Provider Interview Questions

Name of organization:

1. Who is the target population of your program?

2. How does your program select clients to participate in the Housing First program?

3. At any one time how any tenants can this program accommodate?

4. How would you define "Housing First"?

5. In your opinion, what are the major principles of a Housing First approach?

6. In order to incorporate Housing First principles did your organization develop a new program or make changes to a previously existing one?
   - Was it your choice to work with the Housing First model or was it due to an organizational change in program structure?
   - If it was your choice, what attracted you the most to Housing First?

7. In your opinion, what are the major differences with the Housing First approach to other approaches you have dealt with?
   - If you have not dealt with other approaches, what is your opinion of perceived differences?

8. In your opinion, what do you believe are some of the major benefits to the Housing First model?
   - What do you believe are some of the limitations to this approach?
   - Are there instances when you disagree with this model?

9. What type of supportive services does your program provide?
   - Are they mandatory or voluntary?
   - Are they permanent or temporary?
   - Does your program require sobriety?

10. Do you believe individuals need to either limit or abstain from drug and alcohol use for a period of time before they can effectively live on their own?

11. Are tenants required to make any financial contribution?

12. What actions would lead to a tenant being removed from the program?

13. How would you classify or describe the approach you take to dealing with your clients? (Personal characteristics i.e. firm, empathetic, judgemental etc.)

14. Do you have your own approach/technique to dealing with new clients or do you follow the approach outlined by your organization?

15. What kind of expectations do you have for your clients?
- Do they generally meet or exceed your expectations?

16. In your opinion, do you believe other programs endorse different values and perspectives in the context of their service delivery?
- What is the nature of these differences, if any?
- Do you believe there is still a place for these different approaches?
- Do you believe other organizations have a more effective approach to dealing with this target population than the one utilized by your organization?

17. What are or were some of the main challenges for your organization in implementing a Housing First Program (i.e. political challenges, staff challenges, financial challenges)?

18. Do you think Housing First might not work for some individuals?
- Who would those individuals be?

19. What do you believe is the most challenging aspect of service delivery within your program? (ie. implementation, the clients supported daily living, tenancy conflicts etc.)

20. How much collaboration is there with other service providers or health care professionals within your community?

21. Do you choose the housing placements for your clients?
- If not, are there many options in your city for individuals to choose their housing placement?

22. Based on your personal experience, or the experience of your organization, what would you recommend to other service providers or supportive housing programs trying to transition or implement a Housing First approach?

Appendix B: London CAReS Client Interview Questions

1. How were your health care needs being met before your involvement with London CAReS?
2. How has your health changed since you've been involved with London CAReS?
3. How were your housing needs being met before involvement with London CAReS? (prompt: ie. furnishing, utilities, groceries)
4. How are your housing needs being met since your involvement with London CAReS? (prompts: furnishing, utilities, groceries etc.)
5. What are some of the most positive experiences you've had in your involvement with London CAReS? How easy was it to become involved?
6. What are some challenges you've experienced with London CAReS?
7. How could London CAReS be improved?
8. How many different agencies are you working with? (prompts: income, health, legal etc)
9. How has London CAReS helped you work with all of these agencies?

Appendix C: STEP Home Focus Group Participants

Participant 1: Waterloo Social Planning

Participant 2: Cambridge Shelter Corporation, Streets to Housing Program

Participant 3: Cambridge Shelter Corporation, Shelters to Housing and Streets to Housing

Participant 4: YMCA Kitchener/Waterloo Shelters to Housing

Participant 5: YMCA Kitchener/Waterloo Shelters to Housing

Participant 6: Region of Waterloo Social Planning

Participant 7: The Working Centre, Kitchener/Waterloo, Streets to Housing Stability

Participant 8: The Working Centre, Kitchener/Waterloo, Streets to Housing Stability

Participant 9: House of Friendship, Kitchener, Shelter to Housing

Participant 10: House of Friendship, Kitchener, Shelter to Housing

Participant 11: Lutherwood Housing Services, Kitchener/Cambridge/Waterloo, Whatever it Takes

Participant 12: Grad Student, Laurier University, "Transforming Services and Housing for People with Mental Illness" Project

Participant 13: Grad Student, Laurier University, "Transforming Services and Housing for People with Mental Illness" Project

Participant 14: Grad Student, University of Western Ontario

Appendix D: Western University Ethics Approval

Research Ethics

Use of Human Participants - Ethics Approval Notice

Principal Investigator: Dr. Godwin Arku
File Number:105137
Review Level: Full Board
Protocol Title: Service providers and tenants perceptions of the Housing First model in Southern Ontario
Department & Institution: Social Science\Geography,Western University
Sponsor:
Ethics Approval Date: May 06, 2014 **Expiry Date:** August 31, 2015

Documents Reviewed & Approved & Documents Received for Information:

Document Name	Comments	Version Date
Recruitment Items	Email script to service providers	2014/03/11
Instruments	Interview guide for service providers and tenants	2014/03/11
Advertisement	Hamilton Flyer (Clean Version)	2014/04/30
Advertisement	London Flyer (Clean Version)	2014/04/30
Letter of Information & Consent	Letter of Information for service providers in Hamilton (Clean version)	2014/04/30
Letter of Information & Consent	Letter of Information for service providers in London (Clean version)	2014/04/30
Letter of Information & Consent	Letter of Information for service providers in Waterloo (Clean version)	2014/04/30
Letter of Information & Consent	Letter of Information for tenants in Hamilton (Clean version)	2014/04/30
Letter of Information & Consent	Letter of Information for tenants in London (Clean version)	2014/04/30
Letter of Information & Consent	Letter of Information for tenants in Waterloo (Clean version)	2014/04/30
Response to Board Recommendations	Response to documents	2014/04/30
Revised Western University Protocol	Western protocol (Clean version)	2014/05/30

This is to notify you that The University of Western Ontario Research Ethics Board for Non-Medical Research Involving Human Subjects (NMREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the applicable laws and regulations of Ontario has granted approval to the above named research study on the approval date noted above.

This approval shall remain valid until the expiry date noted above assuming timely and acceptable responses to the NMREB's periodic requests for surveillance and monitoring information.

Members of the NMREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussions related to, nor vote on, such studies when they are presented to the NMREB.

The Chair of the NMREB is Dr. Riley Hinson. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Appendix E: Curriculum Vitae

Name	James J. Kennedy	
Education	King's University College London, Ontario, Canada 2007-2011 B.A	
	Western University London, Ontario, Canada 2013-2015 M.A	
Teaching Experience	Teaching Assistant for Professor Joanne Greaves in *"Geography of Canada"*	2013
	Teaching Assistant for Professor Karen Ross in *"Latin America and the Caribbean"*	2014
	Teaching Assistant for Professor Abednego Ayree in *"Environment, Economy and Society"*	2014
	Teaching Assistant for Professor Godwin Arku in *"How Humans Interact with the World"*	2015